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Medical Times

A Monthly Journal of Medicine, Surgery and the Collateral Sciences

Published by THE MEDICAL TIMES COMPANY at 81 Fulton Street

Vol. XLV., No. 11 NEW YORK, NOVEMBER, 1917 Fifteen Cents a Copy One Dollar a Year

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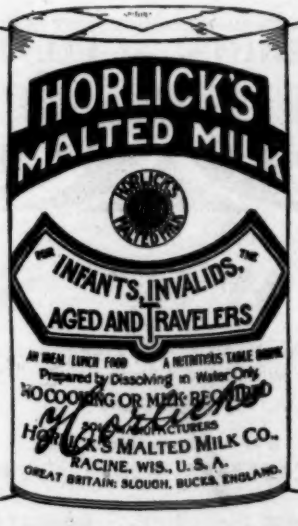

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Medical Times

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Vol. XLV., No. 11 NEW YORK, NOVEMBER, 1917 Fifteen Cents a Copy One Dollar a Year

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Inauguration of James Chidester Egbert, Ph. D. AS President of the Long Island College Hospital.

With simple but impressive ceremonies, James Chidester Egbert, Ph.D., director of the Departments of Extension Teaching and of Summer Sessions of Columbia University, was inaugurated as the President of the Long Island College Hospital, Brooklyn, on October 9.

The beginning of the fifty-ninth year of instruction in the college was fittingly observed by the exercises which made Dr. Egbert, one of the foremost educators in the country, the successor of the late John Alva McCorkle, M.D.

The spacious amphitheatre in the Polhemus Memorial Clinic was crowded with students, alumni and invited guests of the college.

The faculty, in academic robes, occupied the two front rows, while the regents, council and guests sat in the lecture pit.

Dean Otto V. Huffman of the college presided. After prayer by Rev. Dr. A. A. Shaw, this program was carried out:

The Induction.
By Percy S. Dudley, A.B., LL.B.,
President of the Board of Regents of the College.

Acceptance.
By the President of the College.

Salutation.
By William Francis Campbell, M.D.,
Professor of Surgery,
In behalf of the Council, Faculty and Alumni.

Greetings by Delegates.
Hon. Charles B. Alexander, LL.D.
Regent of the University of the State of New York.
In behalf of the State.

Nicholas Murray Butler, LL.D.,
President of Columbia University.
In behalf of the University.

Frank D. Blodgett, LL.D.,
President of Adelphi College.
In behalf of the Brooklyn Institutions of Higher Learning.

Samuel W. Lambert, M.D.,
Dean of the College of Physicians and Surgeons, Columbia University.
In behalf of the Medical Schools.

The greetings of the delegates were of the heartiest nature. The eloquent tribute of President Butler to President Egbert as a Latin scholar, archaeologist, educator and a man made a profound impression on the audience, for the two presidents have been closely associated in the activities of Columbia University for many years. Dr. Egbert was hailed as a living and conclusive argument in favor of a classical education.

Following the formal exercises the new President was presented to the regents, council and faculty at a luncheon served in the college library.

The addresses follow:

THE INDUCTION.

PERCY S. DUDLEY, A.B., LL.B.,
PRESIDENT OF THE BOARD OF REGENTS OF THE LONG ISLAND COLLEGE HOSPITAL.
Brooklyn.

In this momentous epoch, all activities are affected by the world conflict which is going on. All human endeavor is mobilizing for the gigantic struggle. Every economic force, every department of science is called upon to exert an influence on the result. As to each individual, so to an institution such as this, comes the question—What can we do to give the best that is in us?

To the medical profession at large, the answer has been plain and the response to the call immediate. In America, as in Europe, the best traditions of the profession have been worthily sustained; and never have the efforts of its members been more fruitful and beneficent. Terrible as is the toll of dead and wounded by shot and shell, preventive medicine has secured the armies from the scourge of typhoid and dysentery and checked the ravages of typhus and tetanus, which make so dark a record in the history of most previous wars; and modern surgery has saved the lives and limbs of

rhousands who, but a few years ago, would have been helplessly doomed.

In meeting the pressing demands for service near the front, there is danger of neglecting less inspiring but indispensable duties at home. Higher prices and harder living tend to increase disease among those left behind and the advance in the death rate will show that war sacrifices the lives of noncombatants as well as of those who fight hand-to-hand.

We learn by the experience of other countries that it would be a short-sighted policy to strip this country of all its doctors at any time or to cut off the supply of trained men by calling out prematurely those who are preparing themselves for future usefulness. The right policy has been officially adopted by this Government in ordering that hospital interns and fourth, third and second year medical students, upon furnishing proper credentials, be released from the draft until the completion of their training.

This is the correct construction of the Selective Service Act and the sound basis for universal service. It is not intended to check the enthusiasm of the volunteer nor to refuse the willing offer of the patriot, but to steady the supply and maintain the reserve force which mean strength, endurance and ultimate victory. Properly understood, every man is in the service, here or abroad, and to each his turn for action may come; but "they also serve who only stand and wait." The obligation upon each one is to be ready and willing and so to prepare himself that, when the time arrives, he can give his utmost. Then the period of waiting will not be wasted but will be productive and advantageous, as study and practice add knowledge to the brain and skill to the hand.

This obligation rests upon every student of medicine and you are fortunate in that your preparation will increase your usefulness many fold and fit you for the tremendous responsibilities which, now more than ever, burden the medical profession. It is the obligation of this college to help you in this preparation, to guide you in your studies, and to give you practical training in their application. An adequate equipment, a competent teaching staff and unequalled clinical facilities afford a student at Long Island as good a chance to profit by his hard work and to deserve his diploma as he would have anywhere in the country; and a graduate of Long Island has no reason to fear the rivalry of competitors or the test of actual practice. The men who go out from this college will be fit to do their duty and I am sure they will do it.

Now, in this whole matter of teaching and learning medicine, there is something more than the mere imparting and acquiring of scientific knowledge, however profound, something more than research into problems however complex. It is the entrance to a noble profession and both teacher and student fall short if they lack the inspiration of their high calling. There is a spirit of approach, a personal attitude toward the work of your life, which can lift it above material or even intellectual gain and make your profession far more than a means of livelihood. Both professors and pupils should be imbued with this spirit and in these years the ideals should be formed and the standards fixed that will give aim and purpose to your life. An educational institution where such a spirit prevails has an ethical character which is impressed on its graduates and which is strengthened by tradition as the years go on. It prevails in some of our universities and I see no reason why it should not be cultivated and thrive also in a medical college.

Therefore in seeking to fill the vacant presidency of this college it was eminently fitting to select not only a scholar of high attainments and an educator of wide experience, but a man who had been an inspiring leader in the progress of one of our greatest universities, a vital force in its marvellous growth and extension. For such a man would foster and develop the true professional spirit and bring new life and strength to our college.

The Board of Regents, in confirming the unanimous choice of the Council and Faculties, felt that these qualifications were completely met and that the Long Island College Hospital was to be congratulated upon the acceptance of its offer.

Gentlemen, I take pleasure in introducing to you, as president of this college, Dr. James Chidester Egbert, heretofore of Columbia University, but now, as well, of the Long Island College Hospital.

THE ACCEPTANCE.

James Chidester Egbert, Ph. D.,
Brooklyn, New York.

The institution at whose call we are present here today has not as yet reached old age, but is just completing its three score years. Nevertheless, in the period of its existence it has had a most active and useful career, and has been the witness of extraordinary changes in the nation and in the city with whose history its own is so closely entwined.

In the month of March, 1856, a little group of German physicians established what was known as the Brooklyn German Dispensary at 132 Court Street. On October 27, 1857 a meeting was held in this Dispensary at which the organization of a hospital to be known as St. John's Hospital was proposed. This meeting can be regarded virtually as the beginning of the Long Island College Hospital. On November 5, at an adjourned meeting the charter and by-laws were presented and the hospital became a realized fact. In the minutes of December 23 of the same year we find a reference to the "officers of St. John's College Hospital." This is notable as the first instance of this form of the name with which we are familiar. The meeting was important also as the occasion on which the name was changed to Long Island Hospital and Medical College, and action was taken looking to a suitable modification of the charter and by-laws. On February 4 of the following year, 1858, the minutes record a meeting of the "Regents of the Long Island College Hospital" and the final form of the name is then used for the first time. The importance of these changes in title rests in the fact that the College and hospital were evidently closely identified in the minds of the Regents of these early days. In other words these men with keen judgment recognized even at this time the absolute necessity of combining a medical school with a hospital so that clinical opportunities might be at hand for these students.

In the eight months of the year 1858 remarkable progress was made in the development of the institution. The Perry property on the west side of Henry Street between Amity and Pacific Streets was selected as a site for the building. The first Council was organized, and on June 2 the Inauguration Festival took place. In the fall the new building was ready and the college began its active career. The days that followed were, however, filled with anxiety and finally on December 23 of the next year the building was sold and the institution was closed because of financial difficulties. In March, 1860, the College Hospital was reopened and then entered upon a career in the progress of which

we rejoice today. On July 24 the first Commencement was held in the Chapel of Packer Institute. Among the names of those who devoted themselves to the interests of the College Hospital at this time we find Senator Samuel Sloan, Dr. W. H. Dudley, the father of the present President of the Board of Regents, Dr. T. L. Mason, Professors Austin Flint, R. O. Doremus, F. H. Hamilton, and J. C. Dalton. In times such as these we can readily appreciate the courage of these men. When the institution was founded the clouds of war were gathering and every one dreaded the coming of civil strife. The same uncertainty, which we understand so well, prevailed, and any plan, however noble, demanding financial aid from benevolent givers was looked upon with disfavor. The faith and courage of the founders of Long Island College Hospital should inspire us when serious interference with revenue threatens the well being of our universities and colleges.

It is gratifying to record the part taken by the hospital at the time of the Civil War, when it received and cared for the sick and wounded soldiers. In the spring of 1898 during the Spanish-American War a similar service was rendered. All this tended to distinguish the hospital as of special value to the nation and to the city. The Long Island Hospital has not lacked the help of benefactors. In fact, from its earliest history it has received many evidences of the generosity of the citizens of Brooklyn. To this spirit we owe the Hoagland Laboratory, the gift of Dr. Cornelius T. Hoagland, who saw in bacteriology the one science most promising in the field of medicine. Mrs. Caroline H. Polhemus, desiring to establish a memorial to her husband, furnished the funds for the erection of this building in which we are assembled to-day. The hospital proper includes the Maxwell and Arbuckle Memorials, which with the Annex and the Dudley, Herriman and McCorkle Memorials, forming the nurses' homes, complete the group of buildings, affording extraordinary facilities for the study of medicine. This then is the educational institution the titular head of which you are now formally installing. These are simple exercises. The installation of a president of a college is becoming commonplace. Nevertheless there are certain peculiar conditions associated with this occasion which lift it out of the ordinary and deserve careful consideration on the part of all of us.

Our minds at this moment, regardless of the object for which we are assembled, are burdened with the thought that the world is at war. In the presence of this great calamity it becomes increasingly difficult to adjust our thoughts so as to view with reason what is occurring in the world of to-day. Some are tempted to despair, others with sublime confidence in the final triumph of right recognize fully the unfortunate necessity of relying upon military force to bring this triumph, but turn with great satisfaction to all those instrumentalities which tend to ameliorate the results of "man's inhumanity to man which makes countless thousands mourn."

Fortunate indeed is the lot of the officer and student of an institution such as this. Here we train men and women to protect from plague and disease those who are gathering to contend in a righteous cause. Here we learn to heal wounds made by shot and shell. In so doing we prove that mankind is not wanting in the spirit of humanity, but even in this time of war and blood shed is moving toward the goal of true human progress. But this is not all. We must remember that armies and navies will be of little avail without the aid of those who work through these remedial agencies. One who devotes himself to this profession of medicine with unselfish spirit is a true patriot and essential to the welfare of his country. We are looking to you, young men, to the alumni, to the faculty for this patriotic spirit, which will add to the fair fame of this institution for national service in time of national emergency.

Let us turn now to the consideration of this college as one of the educational institutions of this great city.

When Columbia University invited a distinguished citizen of Brooklyn to become its president, the so-called Greater New York did not exist. Brooklyn was a thriving city independent of its neighbor, the metropolis, although there existed an intimate interchange of life and business inevitable with adjoining communities. Today these two cities are one; they have a central government; they have common interests and similar possibilities of development. The drawing together of these two communities is the natural tendency which we all will accept as mutually advantageous. Long Island College Hospital should, therefore, assume its position as located in New York and claim for itself all that such a location implies. For the purpose of professional training a large city it unexcelled and this is true of New York. This college, therefore, should become in every sense a city institution. I would carry this still further and ask not only that we should place ourselves among the institutions of learning of Greater New York, but that we should learn the lesson of most active cooperation. Educational institutions like churches have in other days viewed each other with more or less jealous rivalry, although recently this spirit has been rapidly declining. As these two communities are being more closely drawn together, so I am pleading for much greater cooperation between the colleges of this city. There are diverse views as to the advisability of such intimate relationship. The possible loss of individuality and subsequently of activity and energy are feared. Certainly any form of union which should render such misfortune possible should be deprecated. Interference with institutional independence is not called for. Close cooperation with mutual independence leading to a federation cannot be open to such criticism. From this would come similarity and consequent elevation of standards, an interchange of students, assistance in the selection of instructors, and cooperation in administration. Such united action on the part of the colleges of this city would usher in the day of wonderful development in higher education.

If all this is true of our city colleges in general it is particularly true of professional schools devoted to the study of medicine. This was appreciated in Philadelphia when an attempt was made to bring all the medical schools under one control. Such a complete amalgamation may not seem desirable but the unity of action of which I speak cannot fail to be of advantage. With thoughts such as these in our minds we can understand the significance of the installation of an officer of Columbia University as president of the college.

We should not neglect the fact that the organization of the Long Island College Hospital admits of such action. There is a Board of Regents which presides with judgment and devotion over the interests of the entire institution. There is a council which forms a line between the regents and the faculty. The immediate administrative control of the educational work is assigned to a dean and the faculty. The president of the college is its titular head, and presiding in the council and faculty is the formal administrative officer and educational adviser.

Because such service can be rendered by an officer of

another institution the opportunity is afforded of finding and maintaining community of interest which will be of value to the college hospital and also to Columbia. Having been trained as an aristocrat in education, and for many years believing that the classics were indispensable in the education of a gentleman, as the years of my service at Columbia have gone by, I have become a thorough democrat, until now it is almost an obsession with me to place educational opportunities before all that long for them. This cooperation of which I have been speaking and particularly the union of effort on the part of Columbia University and the Long Island College Hospital, I believe, will tend to increase and extend the facilities for professional training in New York and greater numbers will receive the education they desire.

In closing may I refer to my predecessor, the late Dr. John A. McCorkle. I did not have the pleasure of knowing him, but I desire to record the fact that the influence of his genial spirit still abides. He was a kindly man with a tender heart, a representative of that group of so-called family physicians now so rapidly disappearing. With a broad mind he welcomed innovations which he believed meant the development and growth of the institution he loved.

Mr. President of the Board of Regents, Gentlemen of the Council and Faculty, students of the college, I accept the office of president with deep appreciation of the honor you have conferred upon me, but above all of the opportunity which such an appointment affords. May this day be the harbinger of helpful cooperation which may mean much for the progress of medical education in this great city.

THE MEDICAL SCHOOL AND THE PRESENT CRISIS.*

WILLIAM FRANCIS CAMPBELL, F. A. C. S.,
PROFESSOR OF SURGERY IN THE LONG ISLAND COLLEGE HOSPITAL.
Brooklyn, N. Y.

Fifty-seven years ago, on the eve of the Civil War, the first class was graduated from Long Island College Hospital.

Not since that event have we commemorated any occasion fraught with such deep significance as this we celebrate to-day.

We have assembled to conduct into office a new president.

This for us is no mere perfunctory ceremony.

For fifty-seven years Long Island College Hospital has faithfully served this community; its long roll of alumni attests the fine contribution it has made to the social welfare. Amid the changing times and the ever-advancing standards, through periods of adversity and unstable fortune, it has struggled and it has survived, and it has maintained an honorable place among the eleemosynary institutions of this borough.

You have come to us, sir, at an opportune time—the fallow ground is ready for an abundant harvest. We need the heartening which will come from contact with your broad scholarship, your wise counsel, and your wide experience in advancing the cause of higher education.

We would indulge in no extravagant promise; there is but one pledge we can offer: You will be surrounded by a band of men who are much in earnest, men who are willing to serve and to sacrifice, that this institution founded and nurtured by a host of noble spirits, whose memory hallows this occasion, may remain an abiding memorial to their splendid sacrifices and to their wise philanthropy.

We do not wish this institution to survive if it is not fit to live, but we wish to make it so fit that it cannot die.

This means something more than bricks and mortar, something more than an extensive plant, however modern or replete. There is much in institutional architecture that suggests a formidable coat of mail, wrapped about an attenuated body.

We need often to hark back to basic facts and to readjust our perspective by a consideration of the *raison d'etre*.

Professor Vaughan has recently defined life as function rather than form; and this applies essentially as well to groups of individuals working together as to the single individual working for himself. The hospital represents essentially function rather than form. The hospital is not merely the child of civilization, it is one of the finest flowers of civilization. It represents a by-product of man at his best—man emerging from the age of force to the age of reason—from antagonism to fraternity and cooperation—from economic necessities to economic surplus. Eleemosynary institutions are possible only where economic conditions represent surplus, excess, prosperity—man producing in excess of his needs. Extraordinary endowments are possible only because of extraordinary prosperity. The hospital represents man at work not for himself but for his fellowman.

We would have, therefore, our enterprise dominated by the basic fact that, amid this group of splendid buildings with all its elaborate organization for technical work and systematic education, there stands as the central figure of all its endeavor the patient—his needs dominating every other consideration.

If we would preserve our perspective in due proportion and hold our endeavor in fine balance, we must ever be mindful that the end result of this highly organized effort in ward, in laboratory, in operating room, and in lecture hall, is the salvage of human waste. We receive a patient; we aim to give back to society a useful citizen; and in proportion as we do this efficiently are we an asset to the community and an investment for the state.

The time has come when the relation between the hospital and the community should be readjusted upon an intelligent basis. Why should one of our finest enterprises be subjected to the chagrin of assuming the attitude of a beggar asking alms? The "something for nothing" philosophy—the end of which is always bankruptcy—moral as well as financial, is not for this age.

The efficient hospital is one of the community's best investments, and every dollar that is given to a hospital should be given with the same intelligent discrimination that any other investment is made—the money is given because the enterprise is sound, the management efficient and the returns attractive.

It is this self-reliant attitude which Long Island College Hospital assumes in this community. It asks no alms; it seeks by the worth of its work and its efficiency in human salvage to be worthy of the benefits which may be bestowed upon it—not as an irresponsible beggar, but as a trustee who is ever seeking for security, betterment and definite returns.

And again we have assembled to-day under the shadow of a great war. Gigantic forces locked in a titanic struggle are striving for mastery—forces of which we are an integral part. How can we play a man's part that we may be worthy of a man's heritage?

*Address delivered at the inauguration of President Egbert, Long Island College Hospital, October 9, 1917.

This occasion gets much of its inspiration from the fact that we are addressing a student body, burning with patriotic enthusiasm to serve this nation in its hour of need.

Are we to hide under cover of personal expediency? What is our answer to this call?

Let me remind you that vanity plays too large a part in our estimate of what we should do to play the man's part in this conflict. We are misled by mistaking pride for patriotism, by believing that in order to serve our country we must necessarily wear a uniform.

The larger part of America's manhood is going to perform noble and patriotic service without a uniform. True patriotism is proclaimed by no external trappings. Common mufti is no handicap to patriotic endeavor.

Naaman, the Assyrian, was sick with a grievous disease; he came to the prophet Elijah to be cured, but he came with pomp and ceremony and princely gifts; his vanity craved the exhibition of some mystic rites, and his pride was sorely wounded when the prophet prescribed only a bath in the muddy Jordan.

The common duties performed with common sense and uncommon enthusiasm is the highest service that most of us can render our country in her hour of need.

Sacrifice and service, these are the bone and sinew of patriotism. It's a sacrifice for many of you to stay home and perform the duty at hand, but you may be thereby rendering a larger service.

I do not wish to get far away from the boy's viewpoint—the boy is often right, because his vision is unclouded by an overfed body and a flabby soul. The boy wants to do something big and fine, to justify his own manhood—something big enough to make him "forget past failures and self-contempts" and out of it all to emerge wearing a new nobility.

Let me suggest that this is a war in which the resources of our country are to be so organized that there may result the maximum efficiency.

The government wants the job to fit the man—not the man trimmed to fit the job. It is as irrational to compel a doctor to shoulder a gun as it would be to ask an aviator to dig a trench.

Many of us believe that the best results can be obtained only by a selective draft, but since Congress yielded to the pressure of the so-called more democratic universal draft, the council of national defense are trying to mitigate many of the hardships of this draft by placing the conscripts where they belong according to their economic value.

In view, then, of this mobilization of resources to attain every ounce of strength that our country can put forth, what should be our attitude—we who are not in the field and camp? *This*—we are all potentially drafted for the period of the war, every one of us is going to serve and to sacrifice in order that our country may win this war for human freedom. This college is our cantonment. Your country asks you to prepare to serve her efficiently by preparing for her a finished graduate in medicine.

She needs no half-baked medical students.

It has been said that this great war will be won by the medical profession. Perhaps this is true, but certain it is that a heavy responsibility rests upon the physicians and surgeons of this country.

Our brethren over the sea are sorely pressed. They are calling for reinforcements.

Our Government is now asking for 20,000 medical officers, and may ask for more later.

It means depleted ranks, and gaps to be filled by trained men.

What is our relation as a medical school to this problem?

It is the relation of the munition factory to the firing line.

We can't all be on the firing line, but we can all help to supply the needs of the firing line.

There is more need than ever for the medical school. The embargo which limits the size of our classes should be entirely removed during the period of the war.

The medical student should realize that he is in a peculiar sense preparing himself to serve his country in the high, holy and helpful office of physician. There are heavy tasks ahead for all. The call is for "true hearts, clear heads and clean hands" to help rehabilitate a world grown grim with the scars and disfigurements of war.

President Egbert: On behalf of the Board of Regents, the Council, the, Faculty, the alumni, and the student body, I bear you felicitations and congratulations. I pledge you their hearty cooperation and loyal support, for we believe that your inauguration as our official head marks the rebirth of our institution and a new era of larger usefulness.

THE CHILDREN'S CLEARING BUREAU.

ARTHUR C. JACOBSON, M.D.
CHIEF OF MEDICAL STAFF.
Brooklyn, N. Y.

On October first a unique enterprise was formally launched in the city of New York which will make medical social service history and enormously advance scientific child welfare work.

The Children's Clearing Bureau of the Department of Public Charities marks a radical and large-scale departure from the old methods of dealing with the problem of the dependent child. Through this bureau will pass thousands of children in process of commitment to public and private institutions, or of transfer to some private family in which foster parents of the same religious faith of the children will care for them.

But in passing through this bureau the child will tarry for a period of from one to six weeks, during which time his physical and mental status will be studied exhaustively and accurately determined, and all therapeutic, nutritional and operative needs attended to before his case is finally disposed of.

The final decision will send the child to the home or institution best fitting his problem. He will go in good condition or with a record and suggestions calculated to insure his future good care and welfare and the development of any special aptitudes that he may possess. A sincere attempt will be made to identify supernormal types.

Practically all normal children under eight years of age will go to foster homes, where they will be kept under rigid supervision. It is hardly necessary to state that a good foster home is a better place for a normal child than the most palatial and best administered institution in the world.

When these children are brought to the bureau they have already been thoroughly studied from the ancestral and social sides by investigators attached to the Bureau of Social Investigations. Complete records covering these phases of their history accompany the children.

This "adventure in optimism" has been entered upon at a critical time in the child life of the city, for owing to the present social and economic stress juvenile

dependency is on the increase. Here is constructive and anticipatory work matched against the destructive forces operating in Europe. If child welfare work of this character could be widely extended we would more than repair the ravages of the war. Thus there seems a special fitness and opportuneness in initiating this plan at this time, when the world is engaged in its last war.

The medical staff realize that there is a human as well as a technical side to the examination of these children, and that the bureau is primarily a social service institution. Since the medical examination comes first, much depends upon the tactful initiation of the children by the examining physicians. The children must be made to feel themselves in an atmosphere of friendliness. Effort is made to set up the illusion of a pleasant adventure. The examinations are made in exactly the same way that they would be conducted in a physician's private office—in strict privacy and with all kindliness and patience.

The work of the clinics (dental, eye and ear, nose and throat, orthopedic, speech defects, mental, psychologic, general, etc.) is so unprecedentedly thorough and time-consuming that the possibility of undue fatigue, fear and distruct being set up must constantly be borne in mind. Many children come to us already chronically fatigued, actually ill, or suffering in one way or another from the effects of cruel treatment. The children are not "clinicized" more than once in a given day. *Routine* clinical tests involving the withdrawal of blood, inoculations into the skin, etc., are not performed. Such steps are invoked only in the presence of otherwise insoluble problems of serious import. So much is done for the children diagnostically that ill-advised scientific zealotry is guarded against, and at points sacrificed without compunction in the interest of the human side. This may displease the scientific pedant, but the policy is a well-considered one. Charity has been humanized by the Department.

The children are dressed properly, have attractive dining, sleeping and class rooms and extensive playgrounds, and their personal hygiene is well ordered.

When there are parents, and when the procedure is not open to obvious fallacies, the parents, rather than the children themselves, will be "Wassermannized" if their consent is obtainable.

Recommendations for operative procedures will rest upon the clearest indications that departures from the normal are of such kind and degree as to make the good results of conservative, reparative or constructive intervention more than probable and never speculative. It is very precious material that will be handled, and nothing experimental or faddish will attach to the work.

The clinics co-operate on a co-ordinate basis, and are a functional part of the bureau's social service mechanism. Administrative, scientific and social service operation is smooth for the same reason that the affairs and deliberations of a medico-legal society succeed, in which physicians and lawyers hold executive office and discuss all matters jointly. This state of affairs is possible in the bureau because the staff are fully enlightened as to the meaning of medical social service. It might not be possible were the working group constituted of another, and happily disappearing, type.

The conception and creation of this bureau we owe to the genius of that "incorrigible idealist," Deputy Commissioner William J. Doherty. He is the Aladdin whose wizardry has opened the portals of what must seem to the dependent children of New York a fairy castle, for the bureau is housed in the newly equipped and beautifully located Messiah Home, as it was formerly called. The children of the rich might well envy the *advantages* which these foster-children of the city will enjoy in this Maxfield Parrish-like castle during their stay, but, in the words of the Magnificat, the hungry will be filled with good things, and the rich will be sent empty away. Could Ozanam, founder of the Society of Saint Vincent de Paul, and Charles Dickens, lover and champion of the child life, look in upon these foster-children, they would applaud this fruition of their dreams and bless the founder.

If other things are against the child, says Chesterton, other things must go down. If landlords and laws and sciences are against her, landlords and laws and sciences must go down. With the red hair of one dependent child a fire shall be set to all modern civilization. There shall be a revolution. "The child is the human and sacred image; all around her the social fabric shall sway and split and fall; the pillars of society shall be shaken, and the roofs of ages come rushing down; but not one hair of her head shall be harmed."

115 Johnson Street.

SEXUAL NEURASTHENIA.

BURTON PETER THOM, M.D.,
New York.

The term sexual neurasthenia connotes a neurasthenia caused by some derangement of the sexual apparatus which may be functional or organic—usually the latter.

As every genito-urinary specialist well knows, it is a condition that is quite prevalent, but, contrary to the opinion held by many, it does not necessarily imply impotence. While impotence may be present in some cases, as a rule it is not; the patient's symptoms being of an entirely different character. Masturbation, coitus interruptus and sexual excesses are the causes most frequently associated with the condition, both in the professional as well as in the lay mind, and, while they are undoubtedly causative factors, they are by no means as important as gonorrhœa, which may be called the cause *par excellence* of sexual neurasthenia. The neurasthenia caused by syphilis I do not consider a true sexual neurasthenia, but an entirely different neurosis and consequently I shall not dwell upon it here.

It is at the acute onset of gonorrhœa that the patient in many instances receives the mental wound or shock that later develops into the depressed state which we know as sexual neurasthenia. Usually, however, it does not manifest itself until the venereal disease has passed into the chronic stage, which may be represented by a chronic posterior urethritis, a soft stricture, a chronic prostatitis or vesiculitis. The local symptoms vary with the part involved but the mental symptoms are usually the same whether the condition appears suddenly or gradually. The patient's psyche is changed; he is abnormally depressed and obsessed with the idea that his disease is incurable; his powers of concentration are lessened except in so far as they are centered upon the state of his sexual organs. He lacks confidence in himself and hope in the future and not infrequently wanders from physician to physician seeking relief. Many of these men fall a prey to quacks, who make them more miserable than they were before. It does not always follow that the patient's mental attitude clears up when the gonorrhœal infection is cured. Many of them who are entirely free from

symptoms and whose complement fixation is repeatedly negative still insist that they are not cured. These patients acquire the habit of exaggerating to an undue degree every little happening or appearance pertaining to their sexual organs no matter how insignificant or innocuous it may be, and if they have no symptoms they conjure them up in their imagination. Unquestionably these unfortunates feel truly miserable and not infrequently inflict misery upon those who have to listen to their tales of woe.

Such, briefly sketched, is the clinical picture of the sexual neurasthenic. It is by no means overdrawn. Individuals so afflicted haunt the offices of every genito-urinary specialist.

From coming much in contact with these cases I have had forced upon me the conclusion that while the physical malady from which the patient suffers in the vast majority of cases causes the mental condition to appear, it is not so important in maintaining it as many would suppose. It is my opinion, based upon observation, that the venereal disease *per se* plays but a minor *role* in perpetuating the morbid mental state. I am well aware that this statement is at variance with that generally accepted, nevertheless I hold it to be true. I believe sexual neurasthenia to be a true psychonosema having a phobia as its basis. For, if the mental state of the sexual neurasthenic is analyzed, it will be found that fear and nothing else is at the bottom of it all. If I may be allowed to coin a term they are "sexual hypochrondiacs." They are so unfortunate as to have that rift in their mental make-up so that they are especially susceptible to this particular type of sexual impression. This does not mean that their minds are pornographic, because as a rule they are not.

The treatment of these cases, therefore, should be largely psychic. This does not mean the exclusion of rational measures applied to tangible evidences of venereal disease. In every instance these should be searched for if not otherwise patent. In treating them it is often wise to explain at length the reasons why and the results that will be achieved by treatment. The physician should conduct the case in a spirit of optimism which he should endeavor in every possible way to convey to the patient, because if the patient's fears can be allayed recovery quickly follows. If he is found to have no vestiges or sequelæ of an old gonorrhœa the fact should be painstakingly impressed. Each case must be individualized; I cannot over emphasize this; it is the secret of success. If needed tonics such as iron or strychnin should be given. Electricity I regard more as a placebo, but as it frequently does good by the mental effect produced it should be employed. Cool sponging, the fan spray on the spine, the Winternitz abdominal pack are measures well worth trying. Systematic exercise and the mental diversion afforded by some interesting hobby are to be recommended.

The idea is to get these patients away from morbid introspection in regards to their sexual ailments, real or imaginary and instill into them by constant suggestion by psychic and physical stimuli a healthful frame of mind.

1632 Avenue A.

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EPITHELIOMA OF POSTERIOR PHARYNGEAL WALL CURED WITH THE ELECTROCAUTERY.*

DUNBAR ROY, M.D.,
Atlanta, Ga.

Female, aged twenty-seven years, first seen July 29, 1913. Previous and family history negative. Present history: For last three months had suffered with a soreness and throbbing in her throat. Had been treated continuously without result. Examination showed a rounded ulcer on the posterior pharyngeal wall at center, one-half of which was hidden by the soft palate; dirty grayish in appearance, with edges sharply defined; about one-half inch in diameter, and extending as deep as the superficial aponeurosis. A piece excised showed it to be an epithelioma.

Removal by means of the electrocautery point, well outside of its edges. No reaction and no discomfort followed. Healing perfect under one application. After three years there are no signs of a return.

Unfortunately, clinical observers are too prone to classify all malignant growths of the throat under the general term cancer, without distinguishing between the different forms of carcinoma and sarcoma. This statement is made because the writer has found it almost impossible to correlate all cases recorded, in that many of them were reported in the most unexpected places, and not under the headings where one would expect to find them. As Moreil McKenzie and others have pointed out, the disease is often so extensive when first examined that it is impossible to tell its point of origin.

Textbooks are very vague in the discussion of this subject. It has now been three years since the case here reported has been healed, and there has been absolutely no sign of a recurrence. The results obtained in one case, especially of the cancerous type, certainly do not justify any positive deduction, but the writer believes that the thorough and judicious use of the electrocautery offers the best chance for a good result.

*Read before the 1917 meeting of the American Laryngological Society.

Blood Pressure.

E. E. Cornwall says the pressure of the blood in the arteries is not the measure of the ventricular contraction alone, but the product of that and at least one other constant factor, viz., the resistance in the arterial circuit. Both of these prime factors, though constants, are under the influence of variants; and the variants are numerous and complicated. In fact, so flexible is the circulatory apparatus in its responsiveness to the varying demands of health and disease, and so sensitive is it to the agents which modify both the systolic and the vasomotor activity, that the diagnostic significance of variations in the blood pressure is neither as great nor as definite as might be inferred from a superficial consideration of the subject. The wide variations in blood pressure which are observed in health, and the allowances which must be made for the neurotic and other sub-surface factors in the patient, which affect the systolic contractions and the varying tonus of the arterial musculature, detract much from the face value of blood pressure findings in diagnosis. Recognition of this fact seems to have led recently to a certain amount of reaction from former enthusiasm as regards the diagnostic value of examinations of the blood pressure; and R. C. Cabot (1915) goes so far as to express the opinion, that very little information of clinical value is obtained from the diastolic pressure; but with that opinion the generality of observers probably will not agree. Notwithstanding the confusion of the subject, there seems to be some diognostic inferences of positive and considerable value which can be made from blood pressure findings.

The significance of blood pressure findings in diseases of the heart can be best understood if they are also considered in their general diagnostic relations.—(*Arch. Diag.*)

The American Association of Clinical Research

JAMES KRAUSS, M. D., Permanent Secretary and Editor.

American Association of Clinical Research.

These officers for 1918 were elected by the American Association of Clinical Research at its ninth annual meeting in Boston on September 13-15:

President, Marshall William McDuffee, M.D., New York; first vice-president, Roger M. Griswold, M.D., Kensington, Conn.; second vice-president, Joseph A. Weitz, M.D., Montpelier, Ohio; registrar, Alonzo J. Shadman, M.D., Boston; secretary-treasurer, James Krauss, M.D., Boston.

Research Committee: Geo. L. Monson, M.D., Denver, three years; Alice Conklin, M.D., Chicago, two years; Wm. A. Pearson, M.D., Philadelphia, one year.

Educational Committee: F. S. Barnard, M.D., Los Angeles, three years; John Hall Smith, M.D., Boston, two years; F. C. Askenstedt, M.D., Louisville, one year.

Journal Committee: Geo. L. Le Fevre, M.D., Muskegon, Mich., three years; Alfred W. McCann, A.B., New York, two years; Geo. W. Mackenzie, M.D., Philadelphia, one year.

Membership Committee: G. B. B. Larkeque, M.D., San Pedro de Macoris, R. D., three years; D'l E. S. Coleman, M.D., New York, two years; J. D. Gibson, M.D., Denver, one year.

The place of meeting selected for 1918 is New York and the time of meeting designated is the month of October.

A MOSQUITO CAMPAIGN IN THE CITY OF SAN PEDRO DE MACORIS.*

SALUSTIANO FANDUIZ, M.D.
SANITARY INSPECTOR.
San Pedro de Macoris, R. D.

The town of San Pedro de Macoris has a population of ten thousand inhabitants and a swamp of nematocera, anopheles and culex mosquitoes, in the east part of the city, of four hundred thousand square meters. San Pedro de Macoris is a smart, bustling place, a cosmopolitan town, a busy, sugar exporting seaport. Millions of dollars of American capital are invested in Macoris. This circumstance makes this town interesting to Americans besides being occupied by the United States forces of occupation. The mosquitoes, by the billion, used to invade the town, they invaded the city, the outside bay, and the steamers that were taking sugar outside. The ceilings of the houses used to get black with mosquitoes. The town was formerly called Mosquito y Sol, because of the mosquito calamity.

Stagnant water means death in the tropics, so I commenced my campaign against everything that could contain water, oyster shells, old bottles, tin cans, cocoanut shells, barrels for drinking and industrial purposes, cisterns, tanks, latrines, gutters, and the swamp. All that needed to be properly covered and screened were directed to be covered and screened. What needed to be petrolized or oiled was oiled. The swamp, the white elephant, was at once drained. I personally directed that work, and succeeded in draining the monster into the sea. All the engineers claimed that if the swamp was drained into the sea, it would inundate the city. They had the idea of having a system of pumps, and make immense deposits at the sea shore to collect the water for the pumping and its final disposal in the ocean. The city council postponed the matter as the cost was estimated to be over a hundred thousand dollars. By my experimentation of draining that swamp we have got rid of the mosquitoes with no expenditure for the city. It was no little affair to free the city of mosquitoes. Malaria had raged terrifically there. Formerly, all the members of many families were sick in bed and could not get up even to open the door. By the draining of the swamp the outskirts of the city are not now innundated as before. We are cutting down the mangrove forest and opening a channel to facilitate its draining. In the channel, with full tide, the salt water runs in and the small fish take care of the larvae in the water. Mosquitoes have no place to lay their eggs.

I must mention Major Henry C. Davis, and thank him for his assistance in giving me the men to do the work, and we thank, also, Dr. T. W. Rayson, Past Assistant Surg. U. S. N., for his cooperation and approval of my plans for hygienizing the swamp.

Calle Sanchez, No. 76.

*Read before the American Association of Clinical Research, at its ninth annual meeting, September 14, 1917.

DIETETIC PRINCIPLES.*

BY ROGER S. YORK, M. D.
Boston.

Dietetic principles may be considered a more or less ambiguous title applied to a more or less (generally less) understood subject. To attempt to define it, at least in a way to avoid criticism, would be to tax the mentality of the most of us as we should unconsciously wander into unknown realms. It should suffice, however, to say that the principles embodied in dietary are those which have to do with the administration of food for the accomplishment of a definite purpose.

It is an indisputable fact that, in the past, too little attention has been given to the treatment of disease by diet; or a least to make diet a factor in the treatment.

If we take up any of the text-books on theory and practice, which have been brought out within the last two or three decades, we shall find, under the head of treatment, such phrases as "The value of a nutritious diet requires mere mention;" "A proper, but restricted diet, is recommended;" "A sustaining diet should be judiciously used;" and so on ad infinitum. Star or crystal gazing would be equally intelligible.

We also read such expressions as "The patient should be carefully fed;" which, of course, may mean or refer to the manner in which he *is* fed; whether he should be tied up to a manger, turned out to pasture, or that he should have some one to administer each mouthful and watch closely to observe what the patient does with it. To me it has no reference whatever to what sort of food the patient should be given.

Again we read "General dietetic treatment is of primary importance." What a world of meaning may be hidden in such an ambiguous statement!

In this connection I am reminded of the story of the Irishman whom the doctor, as a parting admonition, told to live on animal food. When he visited Pat the next day he asked him how he got along. Pat replied that "he got along all right on the cracked corn and

*Read before the American Association of Clinical Research, at its ninth annual meeting, September 15, 1907

oats, but begorra Oi couldn't get away wid ther hay." Another patient was told to eat a light lunch at noon. He was seen the next day devouring a wax candle.

It is pleasing to note that the medical profession of today is beginning to recognize the importance of diet in the treatment of disease to a much greater extent than ever before. We no longer tell our patients as did one of our celebrated physiologists a few years ago, that "a person thrives best on that which he likes best."

Unfortunately there are some members of the profession who are still wallowing in the undertow of self deficiency, and who are allowing their minds to swerve along the lines of least resistance. I happen to know of an instance where a patient was told by a leading light in medicine, whose conscience never balked at a fifteen dollar office fee, to "live on plain food." I saw the patient afterwards and he asked me what I thought the doctor meant by plain food? I said probably anything from "scratch," a food for making hens lay to liverwurst, a German antidote for hunger.

Occasionally, of course, we find a patient who is able to carry out any instruction given him to the letter. In evidence of this we have the story of the Irishman whom the doctor had given implicit instructions as to how to take his pills. "One morning Mrs. Sullivan while sitting at the breakfast table with her Patrick, observed Dinny Murphy, their next-door neighbor, running up and down the board walk in front of the house. She called Pat's attention to it, but he could not solve it. Murphy kept up his antics for three mornings; the fourth morning he went hopping and skipping down the walk. This was too much for Mrs. Sullivan. When breakfast was over and Pat had gone to his work, Mrs. Sullivan went over to Mrs. Murphy's and asked her if "Dinny had gone crazy, or phwat ther divvil wuz ther matter wid 'em?" "Divil a bit," said Mrs. Murphy. "Ther docther toild Dinny to take ther little pills phwat he gave 'im three mornin's runnin', then skip a mornin'."

We must admit that it is much easier, for the busy practitioner to tell a patient to "eat what he wants" than it is to try to find out how justifiable such a statement might be.

I trust you will pardon me if I take the time to cite one instance of this kind. Mrs. M——, age 55, well nourished and of good figure, had been troubled with indigestion and bladder trouble for seven years. Everything she ate gave her sour stomach, and irritated the bladder to such an extent that she was obliged to stay pretty close to a bath-room both day and night. Sphincter urinae incompetent, doubtless from irritation, urine leaked away all the time necessitating the wearing a napkin constantly. During all these years she had been treated by the same physician, on an average of once or twice every month. His multiplicity of medicines doing no good whatever, except at times for a day or two. She asked him from time to time what she should eat? His one answer was "eat anything you want, you have nervous dyspepsia and food doesn't make any difference." Suffice it to say that forty-eight hours after being put on proper diet her trouble entirely disappeared and she has remained free from her indigestion and bladder trouble ever since. This was over two years ago and I have seen her quite recently.

Volumes might be written along these lines, but a general summing up of the cases would more properly come under the head of dietetic errors.

The principles involved in dietary should include a careful study of food values, chemical relation to the digestive fluids, and particularly that of cause and effect. We should try to know the significance of the excrementitious principles of the economy, as exhibited by the urine. For example a case of Uricacidemia should be dieted entirely different from one of Oxaluria, though they both belong to the lithemic diathesis. Bennett wrote, as long ago as 1858: "Of all the means of cure at our disposal, attention to the quantity and quality of the ingesta is by far the most powerful."

There are many instances where proper dieting is of more value than medication, though there may be no special system of dieting which may be considered a cure-all. It is safe to say, however, that a large percentage of the petty ailments to which the human flesh is heir are due to dietetic errors. Personally I believe that many of the high blood pressures find their origin in the alimentary canal. It has been said, and wisely, too, that "the average business man digs his grave with his teeth." Because of this fact it should be our duty, as physicians, to apply our knowledge of dietetic principles to every patient who comes within the scope of our abilities.

The tide of humanity today is like a seething torrent. In the bustle and turmoil of business our pulses are throbbing like a trip-hammer. Potentiality is raised to the highest limit, and the vicissitudes of life are too prolific to endure. The strongest physiques, without warning, succumb to the malign influence of wrong living rather than to morbid fecundity.

As was stated in the beginning of this paper: dietetic principles have to do with the administration of food for a definite purpose. The technique of the practical application of those principles may be summed up about as follows:

To determine just what is needed in any given case a quantitative, as well as qualitative, analysis should be made of the urine. This gives a working basis for food discrimination. That is, it tells us what kind of food is best adapted to any particular case for the balancing up the solids to a normal basis. If we give such foods as will increase the deficiencies and decrease the excesses, as shown by the analysis, normal balance should obtain which will go a long way toward correcting faulty metabolism.

The proper use of good drinking water is of vast importance in the practical exemplification of dietetic principles. Most persons do not drink water enough; there are some, however, who, believing that they should drink a lot of water, attempt to drink it all at one time. One patient who came to my office stood at the tap and drank five glasses of water before he quit. I asked him why he did that and he replied that I had told him to drink from eight to ten glasses of water each day, so he usually did it in about two sessions. There are three balky creatures that inhabit certain parts of the universe, whose intellectuality is not measured by their acts: a mule, a goat and a man. Of the three man posesses the least intelligence along certain lines.

At the Middlesex Medical College, where I have been giving instruction in practical dietetics, I endeavor to bring before the students the necessity of establishing a definite reason for giving any particular form of food in the treatment of disease, or more properly speaking the treatment of conditons which are in the main functional.

We are indebted to such well-known men as Hall, Locke and Thompson for their valuable addition to the busy practitioner's armamentarium, in the way of writings and text-books on this most important subject, Dietetics. In Thompson's Practical Dietetics we get a general idea of a proper dietary for almost every known

disease or condition, together with a summarizing of the varous forms of food with their caloric value fully explained.

To say that a patient, in most instances, may be properly dieted from the urinary findings, is to give the best definition of dietetic principles at my command.

Lack of opportunity, or time, perhaps both, is far more often the cause of failure than intentional neglect. In this present day and generation the mind of the average general practitioner, while not lacking in receptivity, is so filled with mental pyrotechnics that he has not the time to decipher every fragmentary portion of the occult. It seems to me that there is a crying need for more simplified technique in the treatment of disease, and less of scholarly effusiveness preceded by tiresome exordiums.

In the physiological equation of life, from the dietetic standpoint, excretion and elimination of solids, should equal the ingestion and imbition of foods less the nutrient values absorbed through the process of digestion and assimilation. Whenever such a ratio of proportion exists, barring organic structural changes, there should obtain a normal standard of health. Excesses and deficiencies destroy equilibrium giving rise to pathologic changes which constitute disease.

The concrete body is but an intricate machine. Its units of heat and force are the products of combustion in its furnace. But if the furnace is crowded beyond its natural capacity its flues become choked and its fire smothered.

The opinion of some of the best authorities is to the effect that we should try to educate our patients up to a better understanding of food values. We should impress them with the fact that the average person eats too much and too fast; that temperance in all things begets good, while overindulgence begets evil. We should exact from them a rigid discipline in the war against disease, and we should try to get their confidence and assistance to that end. We should call their attention to the fact that success or failure largely depends on themselves, and more especially that "eternal vigilance is the price of liberty."

In conclusion I wish simply to state that this, nor anything I might offer is particularly new, but the practical application of basing treatment by diet on the urinary showing is unique if not original: that is "diet by analysis" and it is worthy of trial by any one who desires to justify such a plan of procedure.

The Cerebro-spinal Fluid in Mumps.

That the meningitis which may complicate mumps is cytologically lymphocytic, like that now recognized to be characteristic of acute poliomyelitis, was pointed out in 1904 by Chauffard and Boidin. Among 635 soldiers with mumps transient meningeal symptoms were noticed in 23 per cent., and from cytological examinations of the cerebro-spinal fluid in sixteen of these cases Massary, Tockmann and Luce (*Bull. Acad. Med.*, Paris, 1917, 3 ser., lxxviii, pp. 6-8) found that there was no relation between the gravity of the meningitic symptoms and the number of the lymphocytes—in fact, the clinical manifestations may be alarming when the number of lymphocytes is small. Further, examination of the cerebro-spinal fluid of forty other patients with mumps, but without meningeal symptoms, showed a lymphocytosis of the same character as in patients with meningeal manifestations, and clinical changes, such as an increased content of albumin lasting for a long time, thirty or even fifty days. These results are interesting because puzzling and await elucidation.—(*Brit. M. J.*, Aug. 25, 1917.)

An attack of acute glaucoma causes the sight to fail, excepting in certain cases in which an acute attack has supervened on a long continued chronic stage, with great rapidity from the moment of onset. It is quite unaffected in the early stages of iritis.

War Activities

MEDICAL OFFICERS MADE IN THREE MONTHS.

C. S. Williamson, M.D.,

MAJOR MEDICAL RESERVE CORPS, U. S. ARMY, PROFESSOR OF CLINICAL MEDICINE, UNIVERSITY OF ILLINOIS.

Sufficient time has elapsed since the training schools for medical officers were put into active operation to judge whether anticipated results have been achieved. The raison d'être of the schools lay in the following considerations: The medical officer in the army occupies a position different from that of his civilian confrère, in that he must assume responsibility of a large amount of administrative work, which must be done along lines identical with those used by the rest of the army.

A member of the Medical Officers' Reserve Corps, transplanted to active duty in the army, must be familiar with the organization of the army, its rules of procedure, its system for placing responsibility, its relation to the civil authorites, and, lastly, with that unwritten code known as the customs of the service. Further, he must know accurately the relation of the medical department to the line officer in order that his duties may effectively be performed. Now, these things, while less formidable to learn than the professional knowledge that the physician has already acquired, nevertheless require study, drill and practical application. The training camps have been instituted to instill this knowledge. Starting with the assumption that the physician is familiar with the practical aspects of medicine and surgery, the three months of intensive training supplies the thing lacking to develop him into a competent army medical officer.

One of the difficult things to acquire is the army viewpoint. If a civilian physician were to have suddenly thrust upon him a group of wounded men of whom one or two had severe penetrating abdominal injuries and the rest only slight cuts, what would he do? First, he would care for the severely wounded men by getting them to a hospital and possibly operating upon both at once. He would leave the slightly wounded to shift for themselves, if need be. The army medical officer after an engagement evacuates them all, unless the injury is such that a soldier should not be immediately transported. If he must make choice between the very severely wounded and the less so, the army medical officer gives preference to the latter. This is due to the fact that his primary duty is to keep the number of the effectives up to the highest possible point. Humanitarian considerations come second. This probably sounds shocking to the average layman, but war at best is shocking.

The army medical officer is primarily a sanitarian. The layman is apt to think of such a man of higher rank as performing numbers of major operations and seeing numerous sick men, whereas a division surgeon is more concerned with the problems of preventive medicine and sanitation than with the technique of taking off a leg. Junior officers do most of the strictly professional work.

It is so important to have the sanitary end of the problem properly done that each division has a special medical officer, normally a Lieutenant Colonel, who functionates solely as a sanitary inspector of that division. It is his duty to advise the division surgeon, and through him the Commanding General, concerning

sanitary measures for the health of the troops. So long as the health of the troops is normal the operation of the sanitary service is practically unnoticed. Army sanitation is a difficult task at best.

When one remembers that in the field only the most limited supplies are available, and that the camp has often to be made in poor surroundings; furthermore, that the soldier is subjected not only to the physical and psychical strain of marching and fighting, but to inclemencies of the weather, it may be understood that the sanitary problems are of first magnitude.

Questions involved in these problems are explained in the course taught at the training camp. A civilian physician of good training can effectively take up the duties of an army medical officer after attending such a school. Some physicians, by virtue of a highly specialistic training, are adapted for hospital work and will, of course, be used in such capacity.

It may interest the lay reader to know just what the medical officer is taught in the training camps. First, he learns what every officer in the army must know, i. e., the general plan of organization of the army, the necessary portions of the drill manual, army regulations, which form a sort of organic view of the army, the special regulations, which fill a fair-sized volume relating to the Medical Department, and so on. The medical officer must drill his own sanitary troops. Army regulations deal with all sorts of things too numerous to mention in detail, but in general having to do with the fundamental method of procedure in army matters. One chapter may deal with ceremonies as part of a review, a funeral, the visit of a foreign dignitary, or courtesies proper to exchange between officers of different services. Another tells in detail how to go about getting supplies, how to take care of them and to account for them if lost, damaged, stolen or used up. Another discusses the difficult questions of responsibility and accountability, for it is evident that some individual must be held accountable for property intrusted to his keeping.

The drills must be learned by the prosaic method of doing them oneself, for nowhere is it truer than in the army that one is not fitted to command who cannot obey. This exercise is also a good way for the newly arrived physician to get himself into better physical condition. The majority of those physicians who have come to us have found outdoor work strenuous at first. Most of them soon become accustomed to it and say they have not been in such good condition for years.

The obese often lose from fifteen to twenty-five pounds; the thin register substantial gains.

The average age of medical officers is well over 35. At this time of life men are generally settled in their habits, and, however willing they may be to comply, it is a matter of some difficulty for them to readjust themselves over night. To put the matter concretely, to a man who has been accustomed to get up when he liked, go to bed when he liked, and dress as he liked, it is disconcerting to be awakened at 5:15 and be fully dressed and in line at 5:30. It means springing out of bed promptly and getting busy—very busy. To be in bed with the lights out at 10 is not so hard, for he is generally dog tired. To be inspected minutely, as the officer later will inspect his personnel, is a fine object lesson, but it comes a bit hard at first.

One might suppose that the question of submitting to superior authority would be the most difficult of all, but results have surpassed our expectations. It was soon found that officers who had attained real prominence in the medical world were most ready to get into the spirit of military life. An energetic officer of 30 or 35 who shows a distinct capacity for administrative work and can command men may be put in with a regiment either as a senior or junior officer, according to his ability. Another may be given charge of an ambulance company or a field hospital. It has often happened that two or three attempts are necessary to find the best place for a man. Some have been teachers in medical colleges, and range from department heads in large universities to junior assistant, and such have been largely utilized as instructors.

The health of the army is, in general terms, more dependent on sanitary inspectors than on any other single group. They occupy positions calling for tact, for theirs is the necessary but unpleasant duty of calling attention to defects in sanitation of various organizations, and to insist on prompt and effectual correction. The importance of this work is probably imperfectly realized, but to use the words of a distinguished authority, "If camp diseases can be controlled and prevented, it is evident that during a campaign good sanitation will save more lives than the most perfect surgery." To acquire the special training necessary to do this work efficiently all student officers receive instruction, both theoretical and practical, along these lines, and those men who show a special proficiency are assigned to this branch.—(*N. Y. Times.*)

Exemption of Medical Students and Interns From the National Army.

Additional methods of procedure for carrying out the regulations prescribed by the President for exempting medical students and hospital interns (*The Journal*, September 8, 1917, page 830; also September 15, 1917, page 917) have just been issued.

Application of Intern or Student Not Called.

Interns and students who shall not have been called by a local board may enlist in the Medical Enlisted Reserve Corps, such enlistment entitling them to discharge from draft if thereafter called.

An application for enlistment under this paragraph must be forwarded to the Surgeon-General with the affidavit of the applicant, supported by the certificates of his school authorities, showing his present status as intern or student, and particularly how long he has been an intern in the one case, or the year of the medical course that he is pursuing in the other.

Internship Limited to One Year.

An intern who has served one year or more as such will not be enlisted in the Medical Enlisted Reserve Corps under this regulation.

May Enlist Later in Medical Reserve Corps.

An intern who is enlisted in the Medical Enlisted Reserve Corps hereunder will be called into active service under his enlistment, if his services are needed, at the end of one year of internship. Applications for commission in the Medical Reserve Corps, from interns who at the expiration of one year's internship are called for duty as members of the Medical Enlisted Reserve Corps, or from interns whose year of internship is about to expire, will receive proper consideration.

Medical Student Must Complete Course.

A medical student (undergraduate) who is enlisted in the Medical Enlisted Reserve Corps hereunder will be called into active service under his enlistment, if his services are needed, on failing to pass from one class to another, or on failing to graduate.

Those Called By Draft Board.

Interns and students who shall have been called for service by a local board under the selective draft law may be discharged from the draft, on condition that they shall enlist in the Medical Enlisted Reserve Corps.

Call to Active Duty.

It will be the policy of the Surgeon General as a rule to recommend discharge from the draft on tne condition indicated, the discharge to be followed by a call to active duty under the enlistment in the Medical Enlisted Reserve Corps at the expiration of a complete year of internship or on the failure of the student, undergraduate) to pass to the next higher class or to graduate.

Reports of Status Necessary.

Interns and students who are enlisted in the Medical Enlisted Reserve Corps by virtue of these regulations, and are not called into active service under such enlistments, are required to report their status to the Surgeon General as follows:

Interns, at the end of each three months' period, such report to show the total amount of internship since graduation, and to be countersigned and attested by the medical superintendent of the hospital.

Students, at the end of each semester, such reports to show whether the students qualified for advancement, and to be countersigned by the deans of their respective schools or by subordinate officers representing the deans.

Recognized Internships.

In the execution of these regulations the department will not recognize internships in hospitals, sanatoriums or other institutions conducted for profit, or in small private hospitals (fifty beds or less), or new internships established or added since May 18, 1917, to those previously existing, at any hospital, excepting such as may have been newly established and added by reason of a proportional increase in the bed capacity of such hospital; nor will it recognize internships in the case of any graduate appointed thereto later than August 1 following his graduation.

Students Who Have Been Accepted for the Draft to Continue Their Professional Studies.

The Surgeon General of the Army has approved the following forms which are to be filled out and returned to him. This should be done without delay. It must be understood that medical students permitted to continue their studies under these provisions are not exempted and may be called to duty at any time that the President deems their services especially needed by the Army.

Affidavit of Dean and Student.

The dean or secretary will make his affidavit and send it to the student accepted for the draft, who will make his affidavit and forward both affidavits with a copy of the order of the local board calling him to report for physical examination (Form 103), to the Surgeon General of the Army, Washington, D. C. Affidavits must be executed by some one legally qualified to administer an oath.

AFFIDAVIT OF THE DEAN OR SECRETARY OF THE MEDICAL SCHOOL.

I, ..., Dean of ....Medical School, do swear that the official records of this school show that..... entered this school....., ... and that he has successfully done the work of his class.
Mo. Yr.

.....

Date.....

Subscribed and sworn to before me this..... day of....., A. D. 1917.

.....

AFFIDAVIT OF THE STUDENT ACCEPTED FOR THE DRAFT.

I, ..., having been accepted for the draft by local board..... am a student in.....Medical School in the second third year, having entered said school....., ... fourth
Mo. Yr.

I hereby apply to the Surgeon General of the Army to be ordered to report at once to my local board for military duty and thus to be inducted into the military service of the United States, immediately thereupon to be discharged from the National Army for the purpose of enlisting in the Enlisted Reserve Corps of the Medical Department. I have been called by local board ....., physically examined and accepted, and there is no claim for my exemption or discharge now pending and I have not been ordered to military duty. In compliance with the supplemental regulations governing the execution of the Selective Service Law authorized by the President and issued under date of August 29, 1917, I am making this application and am enclosing herewith a copy of the order of the local board calling me to report for a physical examination (Form 103).

I do hereby pledge myself to enlist in the Medical Enlisted Reserve Corps and to promptly respond either before or after my graduation on an order from the Surgeon General to active duty.

.....

Date .....

Subscribed and sworn to before me this..... day of .....A. D. 1917.

.....

AFFIDAVIT OF THE MEDICAL STUDENT WHO HAS BEEN ACCEPTED FOR THE DRAFT, AND IS NOW ON ACTIVE DUTY IN A CANTONMENT OF THE NATIONAL ARMY.

I, ..., having been accepted for the draft by local board ....., am a student in.....Medical School in the second third year, having entered said school....., ... fourth
Mo. Yr.

I hereby apply to the Surgeon General of the Army to be ordered to be discharged from the National Army for the purpose of enlisting in the Enlisted Medical Reserve Corps of the Medical Department. I have been called by local board ....., physically examined and accepted, and am now in active service in the National Army at Camp....., located at ....., ... In compliance with compiled rulings No. 11 of Provost Marshal General, Par. 1 (Z), I am making this application and am enclosing herewith a copy of the order of the local board calling me to report for a physical examination (Form 103).
City State

I do hereby pledge myself to enlist immediately in the Medical Enlisted Reserve Corps and to promptly re-

spond either before or after my graduation to an order from the Surgeon General to active duty.

.....

Date.....

Subscribed and sworn to before me this.....day of....., A. D. 1917.

.....

Provision for Permitting Hospital Interns Who Have Been Accepted for the Draft to Temporarily Continue Their Professional Duties.

In accordance with the supplemental regulations authorized by the President, the Surgeon General of the Army presents the following form to be filled out and returned to him. This should be done without delay. It should be understood that hospital interns permitted to continue their hospital duties under these provisions are not exempted from the draft and may be called to duty at any time that the President deems their services especially needed by the Army. The spirit of the supplemental regulations issued by the President does not permit the recognition of an internship continuing more than twelve months.

The superintendent of the hospital will execute his affidavit, ask the drafted intern to fill out his and return both affidavits with a copy of the order of the local board calling him to report for physical examination (Form 103), to the Surgeon General of the Army, Washington, D. C. Affidavits must be executed by some one legally qualified to administer an oath.

AFFIDAVIT OF THE SUPERINTENDENT OF THE HOSPITAL.

I, ..., do swear that I am Superintendent of .....Hospital located at....., ..., and
City State
that ....., M.D., is a bona fide intern in this hospital, devoting his entire time to his intern work and receiving therefor no compensation; that I regard his continuance in this position as essential to the best interests of this hospital; that the daily average number of patients in this hospital is ....., and that the number of interns in this hospital is.....; that the drafted intern herein specified began his internship ....., ..., ..., and it naturally terminates....., ..., ...
Month Day Year
Month Day Year

.....

Date.....

Subscribed and sworn to before me this..... day of....., A. D. 1917.

.....

AFFIDAVIT OF THE DRAFTED HOSPITAL INTERN.

I, ..., having been accepted for the draft by local board.....am an intern in.....Hospital located at.....,
City
..... I graduated from .....
State
Medical School....., ... I began my internship in this hospital ...,....., ..., ...,
Mo. Yr.
Mo. Day Yr.
and my term of service expires....., ...,
Mo. Day
.....
Yr.

I hereby apply to the Surgeon General of the Army to be ordered to report* at once to my local board for military duty and thus to be inducted into the military service of the United States, immediately thereupon to be dscharged from the National Army for the purpose of enlisting in the Enlisted Reserve Corps of the Medical Department. I have been called by local board..... ....., physically examined and accepted, and there is no claim for my exemption or discharge now pending and I have not been ordered to military duty. In compliance with the supplemental regulations governing the execution of the Selective Service Law authorized by the President and issued under date of August 29, 1917, I am making this application and am enclosing herewith a copy of the order of the local board calling me to report for a physical examination (Form 103).

I do hereby pledge myself to enlist in the Medical Enlisted Reserve Corps and to promptly respond at any time to an order from the Surgeon General to active duty.

.....

Date .....

Subscribed and sworn to before me this..... day of....., A. D. 1917.

.....

* This report may be made in person, by mail or by telegram.

Organization of the Medical Department of the United States Army.

Lt. Col. W. W. Reno, Medical Corps, U. S. Army, says the regular army of the United States consists of sixty-four regiments of infantry, twenty-five regiments of cavalry, twenty-one regiments of field artillery, a coast artillery corps and the various staff corps and departments. In the present war it is reinforced by the National Guard, the first increment of the national army, and as many other increments as may be necessary. The largest army staff department in point of numbers in officers and men is the Medical Department.

The Medical Department consists of one surgeon general, with the rank of major general during the active service of the present incumbent of that office, and thereafter with the rank of brigadier general; a Medical Corps; a Medical Reserve Corps; a Dental Corps; a Veterinary Corps; an enlisted force; the Nurse Corps, and contract surgeons. The Medical Corps consists of commissioned officers below the grade of brigadier general, proportionally distributed as follows: Colonels, 3.1 per cent.; lieutenant colonels, 5.4 per cent.; majors, 23.7 per cent; captains and lieutenants, 67.8 per cent. This ratio gives practically one field officer—colonel, lieutenant colonel, major—for every two captains and lieutenants. The total number of such officers is approximately equal to seven for every 1,000 of the total enlisted strength of the regular army authorized from time to time by law.

The enlisted force of the Medical Department consists of the following personnel, who are not included in the effective strength of the army nor counted as a part of the enlisted force provided by law: master hospital sergeants; hospital sergeants; sergeants first class; sergeants; corporals; cooks; horseshoers; saddlers; farriers; mechanics; privates first class, and privates. The

total number of enlisted men in the Medical Department is approximately equal to five per cent. of the total enlisted strength of the army. In time of actual or threatened hostilities, the Secretary of War is authorized to enlist or cause to be enlisted in the Medical Department such additional number of men as the service may require. The number of enlisted men in each of the several grades is as follows: master hospital sergeants, 0.5 per cent.; hospital sergeants, 0.5 per cent.; sergeants first class, 7 per cent.; sergeants, 11 per cent.; coporals, 5 per cent.; and cooks, 6 per cent. The number of horeshoers, farriers and mechanics in the Medical Department is one each to each authorized ambulance company or like organization. The number of privates first class is five times the number of privates. Privates, first class, of the Medical Department are eligible for ratings for additional pay as follows: as dispensary assistant, two dollars a month; as nurse, three dollars a month; as surgical assistant, five dollars a month.

The Nurse Corps (female) consists of one superintendent, a graduate of the hospital training school, whose compensation is $1,800 per annum, and as many chief nurses, nurses, and reserve nurses as may be needed. The superintendent and members of the Female Nurse Corps are paid at the following rates: Superintendent, $1,800 per annum; female nurses, fifty dollars per month for the first period of three years' service; fifty-five dollars per month for the second period of three years' service; sixty dollars per month for the third period of three years' service; and sixty-five dollars per month after nine years' service. All female nurses are entitled, in addition to the rates of pay as herein provided, to ten dollars per month when serving beyond the limits of the States comprising the Union and the Territories of the United States contiguous thereto, excepting Porto Rico and Hawaii, and to cumulative leave of absence with pay at the rate of thirty days for each calendar year of service in said corps; and when serving as chief nurses their pay may be increased by authority of the Secretary of War, such increase not to exceed thirty dollars per month. All nurses are also entitled to quarters, subsistence and medical attendance during illness.

The Medical Reserve Corps consists of medical officers of the rank of first lieutenant, captain and major who are available for temporary service in time of need. The proportion of reserve officers in the various grades cannot exceed the proportion established by law for the regular army medical officers, except that an unlimited number of first lieutenants can be appointed. Reserve officers when on active duty are entitled to the pay and allowances of regular officers. Reserve officers on active duty take temporary rank among themselves and in their grades in the organization to which assigned, according to the dates of orders placing them on active service. They are promoted in accordance with such rank to vacancies in volunteer organizations or to temporary vacancies in the regular army thereafter occurring in the organizations in which they shall be serving. They are not entitled to retirement or retired pay, and are entitled to pension only for disability incurred in the line of duty and while in active service. Any officer who, while holding a commission in the Reserve Corps, is ordered to active service by the Secretary of War, is from the time he is required by the terms of his orders to obey the same, subject to the laws and regulations for the government of the army of the United States.

The proportion of medical officers authorized for an army being seven for every 1,000 enlisted men, the regular army and National Guard having approximately 600,000 enlisted men, this number calls for 4,200 medical officers. To meet this demand there are about 800 medical officers in the regular army Medical Corps and 1,200 in the National Guard. This leaves a shortage of 2,200 for the regular army and National Guard alone. The national army of 500,000 men needs about 3,500 medical officers. Each new increment of the national army, for its immediate needs, must have approximately 3,500 medical officers. Additional medical officers are needed for recruiting parties, general hospitals, specialist hospitals, clearing hospitals, embarkation and debarkation hospitals, base hospitals, medical supply depots, convalescent camps, casual camps, rest stations, evacuation hospitals, evacuation ambulance companies, flying surgical units, laboratories, research units and many other places. Also thousands are needed in England and France to assist the medical department of the British and French armies. Then, too, a large increase over the number actually needed is required to replace losses due to death, discharges on certificates of disability, desertions and other causes. It has been estimated that 24,000 medical officers of the reserve are needed at the present time. This huge number does not include the tremendous needs of the Red Cross.

The rates of pay of medical officers are as follows:

RATES OF MONTHLY PAY FOR MEDICAL OFFICERS.

	Entrance pay.	After 5 years.	After 10 years.	After 15 years	After 20 years.
First Lieutenant	$166.67	$183.33	$200.00	$216.67	$233.33
Captain	200.00	220.00	240.00	260.00	280.00
Major	250.0	275.00	300.00	325.00	333.00
Lieutenant Colonel	291.61	320.83	350.00	375.00	375.00
Colonel	333.33	366.67	400.00	416.67	416.67
Brigadier General	500.00	500.00	500.00	500.00	500.00

In addition to this, quarters, fuel and light, mounts for captains and lieutenants when necessary, and certain other allowances are furnished. The quarters may be a tent or more pretentious. The rates of pay for enlisted men of the Medical Department are as follows:

Grade.	Initial pay per month.	Increase every enlistment period.
Master Hospital Sergeant	$81.00	$4.00
Hospital Sergeant	71.00	4.00
Sergeant, first class	56.00	4.00
Sergeant	44.00	4.00
Corporal	36.00	3.00
Cooks	38.00	3.00
*Horseshoers	38.00	3.00
*Saddlers	36.00	3.00
*Farriers	36.00	3.00
*Mechanics	36.00	3.00
Private, first class	33.00	3.00
†Privates	30.00	3.00†

*Shall not exceed one each to each authorized ambulance company or like organization.

†Second and third enlistment periods only; after that, one dollar increase.

In addition, privates first class are eligible for ratings for additional pay per month, while they actually perform the duties as such, as follows: dispensary assistant, two dollars; nurse, three dollars; surgical assistant, five dollars.—(*N. Y. M. J.*, Sept. 27, 1917.)

Hospitals at the New Army and National Guard Camps.

Provisions for caring for the health of the soldiers have been made by the Medical Department of the Army in the form of thirty-two hospitals at National Army and National Guard camps. In addition is the enlargement of some thirty hospitals used in connection with officers' training camps, taking over or construction of at least two general hospitals at ports, the increase in the size of two other general hospitals and the building or taking over of a number of general hospitals to be

used for special treatment work. The aim of the Medical Department is to have hospital provision for five per cent. of the enlisted force, and to increase that to ten per cent. Abroad facilities for twenty per cent. of the American expeditionary force will be provided.

At cantonments hospital provision is made for three per cent. of the troops at each camp. A complete modern hospital has been constructed at each, containing at least 1,000 beds. Hospitals at National Army camps are costing approximately $500,000 each, and at National Guard camps, where heating is not required, and sewer connected plumbing is not used, about $400,000. This brings the total cost of the thirty-two hospitals to about $14,500,000. Each hospital has equipment equal to that of the best institutions in the country, although the construction of the buildings is of much cheaper quality.

How the Camp Surgeon and Line Officer Can Assist the Psychiatric Examiner.

The Committee on Clinical Methods and Standardization of Examinations and Reports, a subcommittee of the Mental War Work Hygiene Committee of the National Committee for Mental Hygiene makes the following practical suggestions:

In view of the fact that it will be necessary for the psychiatrists who are assigned to the various military camps to examine a large number of recruits in a brief space of time, it is felt by the committee that this work can be greatly expedited if the assistance of camp surgeons and line officers can be obtained in selecting from those who come under their observation, individuals likely to need neuropsychiatric examination. This can be easily done if the medical officers, dental surgeons and line officers will keep certain fundamental points in mind. We would suggest, therefore, the following: In view of the importance of syphilis and hyperthyroidism in neuropsychiatric conditions, all persons suffering from either of these diseases observed by the surgeons in the ordinary course of their work, be referred to the psychiatrist for further examination. The following personality traits are of such importance indicating possible underlying mental conditions, that line officers should be instructed to refer to the psychiatrist recruits under their observation who exhibit them: Irritability; seclusiveness; sulkiness; depression, shyness, timidity; overboisterousness; sleeplessness; persistent violations of discipline; "queer sticks," cranks; "goats," butts of practical jokes; "boobs," those who have difficulty in comprehending orders—dull, stupid; those showing marked emotional reaction, such as vomiting and fainting, at bayonet drill; peculiarities of attitude, speech or behavior sufficiently marked to attract attention of associates; those resentful of discipline; suspiciousness; sleep walkers; bed wetters; those persistently slovenly in dress; those who have difficulty in executing muscular movements in setting up exercises.

It is also believed that the neuropsychiatric examination of a large number of recruits would be expedited if permission were granted to the psychiatrists in the various camps to train and utilize hospital sergeants or others who might be chosen by the psychiatrist, to make group examinations of recruits for the following conditions: pupillary changes—unequal, irregular, disorders of reaction; absent or increased knee jerks; station and gait disorders; marked tremors in extended fingers; facial tremor on showing teeth. Recruits found by the examining sergeant to exhibit any one of these symptoms should be referred to the psychiatrist for further and more intensive examination.

The Diagnostic Laboratory

Conducted by CHESTER T. STONE, M. D.,
Brooklyn, N. Y.

Examination for Tubercle Bacilli in Sputum Liquified by Pyridine.

Marthe Giraud and E. Derrien (*Soc. de Biol.*, Nov. 18, 1916) recommend the following procedure for tenacious sputum: Add 15 c.c. of pyridine to 10 c.c. of sputum, mix thoroughly and let stand 5—10 minutes till liquification takes place, although no harm results from longer contact. Centrifuge and examine the sediment as usual. They claim that this method is less "brutal" than that by hypochlorite and heat. (By the way, the word brutal in French is sometimes used for various experiments, especially on animals in a way that may mislead kind-hearted persons. It applies to the scientific side of an experiment and means crude, or lacking in delicacy.)

Preservation of Complement.

In making routine Wassermann tests, a considerable factor of the necessary preliminary work is the killing of at least two guinea pigs a week for the necessary fresh complement. As all serologists know, complement kept in the ice box can be used only on two successive days, after which its activity rapidly decreases, and anticomplementary substances develop in the guinea pig serum. A reliable method, therefore, for preserving complement, which would not interfere with the working of the Wassermann test, would be a great saving of time, expense and guinea pigs.

Several methods have already been tried. Noguchi dried guinea pig serum on filter paper, but this proved to be worthless. Freezing (—15 C.) is said to be effectual, but most laboratories are not equipped to produce this temperature. Extra sedimentation has been claimed to prolong complement activity. Austin advocated 40 per cent. dilution of guinea pig serum in 25 per cent. sodium chlorid solution, but this method did not survive. In my hands it was unsatisfactory and was soon dropped. (Salt in excess is inhibitory.)

It was found that sodium acetate, chemically pure, possessed no hemolytic power and did not interfere with the hemolytic system, even when present in excess or in crystalline form. A tentative solution of 10 per cent. sodium acetate in 0.9 per cent. sodium chlorid solution was prepared and repeatedly tested for hemolytic power and anticomplementary action with negative results each time. This solution was then used as a diluent for guinea pig serum in preparing the usual 40 per cent. dilution for complement and parallel tests were made with this and the regular 40 per cent. dilution in sodium chlorid solution on all complement fixation tests.

In no case has the result of the Wassermann reaction varied as between the two complement solutions (unless perhaps a tendency of the acetate complement to give clearer cut reactions), and the unit of complement of both solutions was always the same. Guinea pig serum thus diluted to 40 per cent. with 10 per cent. sodium acetate in 0.9 per cent. sodium chlorid solution, whose unit was found to be exactly 0.1 c.c., was placed in an ordinary refrigerator and tested from time to time for loss of strength. At the end of five days the unit remained constant at 0.1 c.c.; at ten days the unit is 0.11 c.c., and there was no bacterial clouding. This slight loss in ten days is so small as to be insignificant as compared to the practicability of saving over fresh

complement for a week or more, the procedure is so simple, and the reactions from this preserved complement so clear cut, that Rhamy believes a preliminary report should be made at this time, so that other workers may try it out and have the benefit of its use, if satisfactory to them, especially during the hot season, when complement deteriorates rapidly. Further investigation will show what strength solution is most efficient. This diluent works equally well with alcoholic extract or with cholesterin antigen. This 10 per cent. solution of sodium acetate in 0.9 per cent. sodium chlorid solution has the same hydrogen ion concentration as the blood (Hp +7.6).

In preparing the acetate diluent it is well to sterilize the solution to prevent the growth of fungi.—(B. W. Rhamy, M. D., *Jour. A. M. A.*, Sept. 22, 1917.)

Streptobacillus From Urine.

A hitherto undescribed gram-positive streptobacillus has repeatedly been isolated by Celler and Thalhimer from the urine of cases suffering from bladder symptoms. It is of low virulence and large doses injected intravenously into rabbits do not kill the animals. The organism does not usually remain in the circulating blood longer than twenty-four hours. After intravenous injection, the streptobacillus can be recovered from the bladder urine sometimes as early as twenty-four hours, and regular after forty-eight to seventy-two hours. It has also been recovered from the urine secured by ureteral catheterization several days after intravenous injection, but has not been recovered with the same regularity from the kidneys of these animals. This organism seems, therefore, to possess peculiar biologic properties which enable it to maintain itself in the urinary bladder, and probably in the ureter and renal pelvis as well, for an indefinite period.—*Journal of Infectious Diseases,* September, GXI, No. 3.

An Acid Polychrome-Methylene Blue Solution for Routing and Special Staining.

This solution has been found useful in staining frozen sections for rapid diagnosis, and as a differential stain for secretion granules, following eosin.

When methylene blue is boiled with an alkali, the two dyes, methylene violet and methylene azur, and probably others, are formed by oxidation. Unna recognized that this change gradually takes place in old alkaline solutions of methylene blue, and he utilized the resulting "polychrome-methylene blue" for special (Romanowsky stain and modifications), applied to cells and tissue with proper technic, afford a great deal of differentiation and pleasing contrast.

The following method has been devised for the staining of frozen sections fixed in liquor formaldehydi and for staining paraffin sections fixed in liquor formaldehydi, Zenker or alcohol after eosin staining.

An acid polychrome-methylene blue solution is made from methylene blue (Koch f. bac.), 1 gm.; potassium carbonate, 1 gm. and distilled water, 400 c.c., dissolved thoroughly and boiled in a flask for thirty minutes. The methylene blue will be polychromed, and most of it precipitated from solution. When the solution is cool, glacial acetic acid, 3 c.c., is added. The whole is shaken thoroughly until the precipitate is dissolved, and then boiled gently for five minutes, or until the solution is concentrated to a volume of 200 c.c. It is cooled in tap water. The solution is ready for use immediately. It may be used over and over again; it does not precipitate, and it keeps indefinitely.

For staining frozen sections, a few cubic centimeters of the polychrome methylene blue solution are placed in a dish, and in this the sections are stained for one minute. They will not overstain if left much longer. They are then washed in water and mounted in water or glycerin, better in water. A good contrast is obtained in this manner. Nuclei are stained deep purple and connective tissue a bright rose red.

An acid polychrome methylene blue and eosin stain will be found very useful for staining differentially the zymogen, and the alpha and beta granules in the pancreas, after fixation in neutral liquor formaldehydi-Zenker, or liquor formaldehydi-bichromate. The fresher the tissue, of course, the better the preparation.

Forty per cent. dilution of liquor formaldehydi may be kept neutral with an excess of calcium carbonate or lead oxid. Immediately before the tissue is to be fixed, 10 c.c. of neutral liquor formaldehydi are added to 90 c.c. of Zenker's solution without acetic acid, or to 90 c.c. of 2.5 per cent. potassium bichromate. Pieces of tissue from 3 to 4 mm. in thickness should be used. They are fixed for twenty-four hours, washed in running water twenty-four hours, dehydrated in alcohol and embedded in paraffin.

Paraffin sections are treated with (1) potassium permanganate, 1 per cent., one minute; (2) oxalic acid, 5 per cent., one minute, and are (3) washed thoroughly in water; then with (4) an aqueous solution containing 1 per cent. eosin and 1 per cent. potassium bichromate from one to five minutes; (5) wash hastily in water; then with (6) acid polychrome methylene blue, from one to five minutes they are (7) washed hastily in water and differentiated rapidly in 95 per cent. and absolute alcohol, and treated with (8) xylene and balsam.

In properly stained sections, zymogen granules stain deep purple, protoplasm light blue, nuclei light purple, alpha granules brick red, and beta granules dark blue.—(*Jour. A. M. A.*, Sept., 1917.)

The Production of Kidney Lesions with Staphylococcus Aureus Toxins.

Studies to determine the effect of repeated injections of staphylococcus pyogenes aureus upon the kidneys are reported in which killed staphylococcus cultures were injected into animals whose kidneys had already been slightly irritated or damaged at the time the killed cultures were employed. Rabbits were used for the experiments and uranium nitrate was the renal irritant used.

In summarizing the results of these experiments it is noted that with one exception, all the rabbits which were given a preliminary injection of uranium nitrate and repeated injections of staphylococcus vaccine, developed well marked kidney lesions. These lesions while not as extensive as those in a great many human cases, yet in principle were the same, consisting of fibrosis, round-celled infiltration, and destruction of glomeruli.

These experiments seemed to the author to show that rabbits, whose kidneys have been damaged with uranium nitrate, show the lesions of chronic nephritis after repeated administration of staphylococcus vaccine. It is also noteworthy, he states, that killed cultures produce these lesions. Whether the preliminary damage is necessary he has not yet determined, and experiments directed toward the solution of this problem are under way.—(*Jour. Med. Research,* 1917.)

62 Pierrepont Street.

Spasmodic stricture of the rectum is a symptom, not a disease.

The Medical Times

A MONTHLY JOURNAL

OF

Medicine, Surgery, and the Collateral Sciences

ESTABLISHED IN 1872

EDITED BY

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Associate Editor.

Contributions.—EXCLUSIVE PUBLICATION: Articles are accepted for publication on condition that they are contributed solely to this publication.

When authors furnish drawings or photographs, the publishers will have half tones and line cuts made without expense to the writers.

SUBSCRIPTION RATES:

(STRICTLY IN ADVANCE)

UNITED STATES, (Including Alaska, Cuba, Mexico, Porto Rico, Hawaiian and Philippine Islands)	$1.00 per year
CANADA,	$1.25 per year
FOREIGN COUNTRIES IN POSTAL UNION,	$1.50 per year

SINGLE COPIES, 15 CENTS

Definite written orders for THE MEDICAL TIMES are required from all subscribers, to whom the journal is thereafter regularly forwarded. Notify publisher promptly of change of address or if paper is not received regularly.

All communications should be addressed to and all checks made payable to the publishers,

MEDICAL TIMES CO.

ROMAINE PIERSON, *President and Treasurer*

H. SHERIDAN BAKETEL, *Secretary*

81 Fulton Street, - - - New York

Entered as second-class matter, Post Office at New York, N. Y., Act of Congress of March 3d, 1879.

NEW YORK, NOVEMBER, 1917

Eternal Vigilance is the Price of Liberty.

Members of medical profession continue to make a gratifying response to the call of the Surgeon General of the Army for medical officers for the new armies. There should not, however, be any diminution in the activities of medical propagandists because the ever-increasing number of troops being gathered together in various parts of the country are demanding more and more medical men. The number of physicians required for duty with the army depends entirely upon the time of the duration of the war, but physicians should adopt the highest patriotic views and present themselves for duty with the same degree of earnestness that they would if they were assured the war would last for several years.

Despite talks of peace the Government will undoubtedly continue the training of great armies and there will be no let-up until peace proposals have been definitely accepted. For this reason we again urge upon the readers of the MEDICAL TIMES to so arrange their work that they can do their share in the titanic struggle in which the world is now engaged. Many physicians cannot leave their work at the moment to go into active duty and consequently are likely to lose interest in this great and important matter. We urge these men to keep the duties of the army medical officer clearly in mind so when the time comes that they can join the colors there need be no delay. The army will constantly need medical officers on account of the wastage which is natural to such service. For that reason medical men who are not in the army should begin to arrange their professional duties to the end that their services may be given to the country when needed.

Nor should we be unmindful of the needs of the navy. Thousands of physicians must minister to the wants of our brave men afloat. There has been less necessity for the call of physicians to the navy than to the army because the number required is not so great, and the vacancies in the navy's medical department are fewer. If the physician prefers naval duty he should communicate with the Surgeon General of the Navy, Washington, D. C. Whatever his preference, the patriotic medical man should signify his intention of serving his country in some service in a medical capacity.

Intellectual Aristocracy or Democratic Mediocrity?

Casanova (Jacques Casanova Chevalier de Seingalt), author of "one of the great autobiographical revelations which the ages have left us, with Augustine's, Cellini's, Rousseau's, of its own kind supreme," was little better than an idiot in early childhood, both in body and mind. He could recall nothing that happened before he was eight years of age. He remained a moral imbecile all his life.

Nietzsche could not speak until he was nearly three years old, and Zola was a dull schoolboy. Zola's winning of a prize for memory only confirms the tradition about his stupidity.

The backwardness of Sheridan and the imbecility of Goldsmith as schoolboys come to mind. Rousseau developed very slowly; his awakening was late and his intellectual maturity delayed. Edison's teachers thought him stupid.

We are beginning to realize today that special attention ought to be paid our handicapped children. The expenditure would pay, for many a lily would be rescued from the dunghill.

Our present system of education takes mainly into account the children of medium capacity, yet the precious "supernormals" are not among these. Our system is really a most wasteful one. It should be more selective—education for the few, if you like. Why make such a fetish of mediocrity?

If "education can bring out only what is already in human beings," why educate those who have so little in them and actually neglect the children with unusual possibilities?

We have a suspicion, which we are almost afraid to voice, that the very child who appears to us worthless is very apt to be the one with the divine fire in him, disguised by nature for some inscrutable reason.

The very instability for which we may condemn a boy may be the very index of his supernormality. The boy who revolts in the school and in the juvenile court we classify as unstable, vicious, incorrigible, morally insane, etc. He ought to revolt against his environment. The suppressible child, whom we call normal, God only knows why, would not revolt, of course.

We stupidly fail to see the tremendous significance in these things, and actually penalize our potential Rousseaus.

It is perfectly true that among fifty bad boys there may be but one supernormal, but our system of crushing the whole fifty blindly crushes also the supernormal child.

Perhaps our mention of Rousseau is unfortunate. There are those who would endorse any system that crushes the potential Rousseaus. His particular kind of genius does not appeal to the master class. And for that matter, it is quite probable that many respectable (and nothing more) people would wish that no Casanova should ever be born again. Cellini was a wicked man, too, and Nietzsche and Zola monsters. Those

who love not literature would be indifferent as to the fate of our Goldsmiths and Sheridans, and the irreligious would be unable to see the value to human society of theologians like Augustine. After all, we find that the great always seem wicked or useless to some, just as boys of supernormal powers seem wicked or useless to nearly all.

Very often the man who has been highly successful in business or the arts would be classed by experts as a child; in fact, we who are not even experts know such men. What precious social assets such men are.

What test would reveal the potentialities of such men? We know of none. "These tests treat all sorts of persons in the same way, which is the essence of quackery, for no two people are alike in the smallest detail." Such tests would have found Goldsmith unfit, without qualification.

We must find some way of identifying the supernormals, for more than ever the world is going to need them.

But first of all we must develop the proper intellectual attitude on the subject.

"The schools of the future will cost more. Teachers will have smaller, more carefully divided classes. And they will be held responsible for better results."

Maybe; but what, then, of democracy, which is planning the reign of the mediocre?

Birth Control and Industrial Imperialism.

China, that half-awake giant of the East, furnishes much food for medical thought. Her political unrest, her development along lines of scientific, including medical, education, and the economic contentions of the powers within her borders, make her national problem most interesting. The Monroe doctrine of the East, formulated by Japan, jeopards American activities in China, and just on this point hinges the chief menace of future wars.

The enormous population of China, and the possibilities of plutocratic exploitation of the country and people, constitute a temptation that the economic forces of the world will be unable to resist. China is a menace, and is also menaced. She can become a terrible militaristic menace, either in her own behalf, or as the instrument of a superior and controlling nation. She can also become a vast factory and labor mart, for the mastery of which predatory interests will contend. Industrial imperialism, backed by governmental and military forces, will employ the fighting machines that the present war is developing for the economic conquest of China. To inflame the people who will pay the cost of such a conquest, and to set flowing the blood of the boys who will be called upon to fight, will be a simple matter for the artists in international imbroglio.

China merely offers a terrific object lesson of the social necessity for birth control as a preventive of war—and worse things. We say worse things, for the economic slavery of a nation is about the worst thing we can imagine.

But one may be sure that against birth control as a means of salvation for both China and ourselves will be arrayed all the plutocratic forces of the nation, and all those missionary influences which have for so long prepared a cross for the Chinese people in more senses than one.

The preparation for the war that is to come after the war is now proceeding apace, and is obvious to all men who think. In it the exhausted nations of Europe will play no great part, perhaps none. Fresh forces will initiate the new carnival of blood and tears, and the desired reactions of the peoples involved will be easily excited by our manipulators of patriotism, since the fabrication of ostensibly concrete issues will be a simple matter for the betrayers of the simple and good who constitute the masses, and who stand ever ready to be exploited by the real traitors against the nation and against the nation's God.

Have You Any Unfulfilled Wishes?

When one reads the reports of our enthusiastic psychoanalysts, and wonders at the symbolism of dreams and the interpretations placed upon the dreams, one is led to suspect that much of the imagination displayed does not come out of the subconscious minds of the patients, but is derived from the conscious minds of the psychoanalysts themselves.

If you have eaten pie at bedtime and dream of odd things, what's the answer?

The morning after our dream we should go to a psychoanalyst and have it interpreted.

If you dream at all you must be suffering from a neurosis, or at least you ought to be, for one can hardly imagine a dream which our psychoanalysts would not find symbolizing unfulfilled wishes.

We suppose nearly everybody nowadays is more or less neurotic; hence if one harbors unfulfilled wishes he ought to have some sort of a neurosis.

Anyone who takes the balderdash seriously that is appearing on this subject from the pens of some of our psychoanalysts must be seriously neurotic.

If the neurotics whose strange subconscious life is described by some of the psychoanalysts are half as bad as they are diagnosed to be, how can they possibly be helped? When you get through you have the same neurotic that you started with, bad ancestry and all the rest.

It is not merely a question of the patient's childhood experiences, but of his grandfather's experiences. And nothing is done or can be done about the grandfather. He should have been treated by a psychoanalyst and have been born again before the patient before us was born. Re-education of the patient before us doesn't offset this factor.

Your neurotic may have come from a long line of oppressed foreigners. One gets this impression very often in reading the voluminous case reports that are appearing in the literature.

And one wonders oftenest of all how much actual harm is done by the numerous psychoanalytic tinkerers whom nature or nature's God never designed to do such work—harm both to themselves and their victims.

Our Medical Imbeciles' Heyday.

A deep thinker has advised that the Grimm brothers' fairy stories be consigned to outer darkness on the ground that they reveal the deceitfulness of the German mind and endanger the morals and character of our children. He points out that the young brother in these stories always gets the better of his elder relatives by a low cunning, and that his whole course in the world is marked by the successful application of this trait.

This advice makes us think of Hare's figure of speech in describing how the fixing element in one of Ehrlich's dye-drugs attaches the poisonous combination to the parasite, enabling all the other elements in the combination to enter and attack the parasite. Hare says that it is as if several thieves who could not gain the confidence of a householder, finally joined together with another thief, who could worm his way into the

householder's confidence, and, having done so, permit the others to prey upon him.

The advice aforesaid also makes us think of Ehrlich's own comparison of the drug compound to an arrow, the tip of which enters the body and the shaft of which connects the farther end laden with poison to the wound.

Perhaps upon these metaphoric bases some superpatriot in the profession will yet postulate a demand for the renunciation of all phases of German medical science. Perhaps he will act when he gets through with his attempt to conscript the entire medical profession for the war and his curious mind is free for further mischief.

Miscellany

CONDUCTED BY ARTHUR C. JACOBSON, M. D.

Clinical Burlesques.

I.

She was a very high-grade neurasthenic and a very high-class psychasthenic. She had more symptoms than Weir Mitchell ever heard of or noted. Compared with her knowledge Brill's was quite amateurish. Brutally rich.

What hadn't been done for this neurotic female could not be cited. There wasn't anything that hadn't been done thoroughly and well.

She had been up to that place in New England where they put such patients at manual labor; she had been to those sanitaria where personality is reduced to a minimum; she had lived in the open; she had ridden real horses and mechanical ones; she had been dieted and bathed in Germany; she had tried the climate of Cairo and of Buenos Ayres; she had had her vertebræ adjusted and her psyche straightened; she had used the "internal bath"; she had soaked up much high-frequency stuff; she had been in the classes of El Doraldo Can, Prince Royal of the Toltec race and god-like exponent of the Hermetic Philosophy; she had exhausted the materia medica and all her physicians.

You know the kind—anxiety neurosis and all the rest. Afraid to cross the street, etc., etc., etc.

Inevitably she reached the psychoanalysis guy. Some symbolization in *her* dreams! THE TIMES simply won't be mailable if we print 'em.

Well, there were two-hour sessions several times a week and the whole field was covered. All the re-education stuff, too.

Did she improve? Oh, yes, like the Christian Scientist friend of the writer who has a "beautiful" locomotor ataxia gait and naively says that he would not be aware of it were he not reminded by friends.

Of course that didn't last.

Heaven only knows why she came to us, or how we induced her to stop drinking two cups of coffee at every meal. That's all we did and she really got well.

Always thought it funny about those experiments in New York which seemingly went to show that coffee was a harmless, beneficial thing, increasing efficiency and totally innocent of the evil that had been laid against it.

That is, we thought it funny until we found out that the cost of the experiments had been defrayed by one of the biggest coffee firms in the world.

II.

He came into the office one rainy Sunday afternoon. Said he was forty-four and had been ill for two years, during which time he had been treated by two doctors in different towns. The symptoms had to do with the gastro-intestinal tract, although these tended to be overshadowed by psychic disturbances.

The man wore an abdominal supporter; under this were half a dozen three-inch adhesive straps; over this was a curious kind of harness that had been devised by one of his doctors and a maker of supporters, apparently designed to reinforce his other boosters. Without all this support he claimed to be unable to walk with confidence, because of strange internal sinking feelings.

Everything was removed and the abdomen examined. The examination revealed nothing of importance. Otherwise the man was apparently sound. Well nourished. Good sleeper. Worked regularly as a printer.

His medical treatment had included about everything on the calendar.

He was not a smoker, did not use coffee, and the diet was rational enough.

Further inquiry elicited that he used no alcohol during the day but drank a "pint" of beer with his evening meal. Later in the evening he drank another "pint." Before going to bed he imbibed another "pint."

He was induced to dispense with the adhesive straps and the outer harness, and the beer was stopped.

When his gastro-intestinal catarrh cleared up the supporter was finally discarded. No medicines used. All symptoms disappeared.

The only marvellous part of this cure was the giving up of the beer. The actual renunciation of beer by men of this class approaches the miraculous.

Psychopathologic Sex Contrasts and the Woman of Action.

Women of affairs, noted for constructive action, appear to have been never morally insane.

The women of action have been morally good. The figures of Florence Nightingale, St. Catherine of Sienna, St. Hildegarde, St. Brigid and Jane Addams come to mind.

What, then, of Queen Elizabeth and "Bloody Mary"? And what of Catherine the Great, of Russia? The answer is that they were not women of constructive action.

The reign of Mary was a period of reaction; "she resolutely turned her face toward the past and, out of devotion to a bigot (Philip of Spain), did a bigot's work."

Catherine the Great defeated an idiotic and cowardly husband, and carried out a career of international brigandage, including the partition of Poland. She promised good things to the people, but "most of her works came to nothing before she died." Profligacy, brigandage and general unscrupulousness cannot be said to bear any relationship to constructive statesmanship.

According to Professor E. P. Cheney of the University of Pennsylvania Elizabeth's intellectual powers were only moderate and her character too commonplace to experience any great crises in life. "She was not gifted with any of the elements of statesmanship, but was so irresolute, undecided and procrastinating as to cause her most devoted ministers to lose their respect. She ate and drank to excess, while thousands of her subjects were hungry and in abject want. The scandals

of her court were so numerous and sordid as to excite wonder in the minds of foreign diplomats. The entire atmosphere of the court was filled with petty jealousies and intrigue. And to her weaknesses in general she added the particular vice of inordinate vanity. Instead of being one of the greatest characters of English history she was one of its most sordid figures. She did not possess the graces of mind and personality that foster learning and was not endowed with any sense of appreciation for the higher learning or the finer things in life. She was inordinately selfish and rarely generous, except when it led to some personal gratification. She loved flattery to a degree that demanded obsequious attentions from her ministers and courtiers, and debasing servility from her servitors and subjects. Elizabeth was one thing and the golden age of literature which is merely chronologically associated with her reign another thing."

It would seem that the male leaders of the race can be morally insane and yet leave quite a good record to their credit in many cases. Women, on the other hand, reaching places of power, must, in order to give a good account of themselves, be morally good.

Must this trait be ranked as another feminine defect?

Obstetrics and Gynecology

The Value of Vaginal Aspiration as a Differential Diagnostic Procedure in Certain Pelvic Cases.

H. Henderson reports six cases in which the vaginal aspiration of the pelvic tumor was an important diagnostic aid in the differentiation of a pus tube from an ectopic pregnancy. He concludes:

1. It is impossible to differentiate clinically between atypical cases of ectopic gestation and purulent collections in the pelvis.
2. Typical cases of ectopic may be combined with pyosalpinx.
3. In case of a mistaken diagnosis, laparotomy in the presence of pus is a dangerous procedure as well as unnecessarily radical.
4. Vaginal aspiration is comparatively harmless, and may be used in the routine ether examination without materially prolonging the operation.
5. Abdominal aspiration is not safe.
6. Although blood in the pelvis does not always mean extrauterine pregnancy, yet laparotomy is justifiable in the presence of such a finding.—(*Jour. Mich. State Soc.*)

Restriction of Provoked Abortion.

Winter discusses the political aspects of curtailment of population. (*Zentralbl. f. Gynaek.*, 1917, xli, 1.) Before the present war the decline in births was a serious matter, but this takes on a new aspect in connection with the immense losses in the male population. Winter thinks that artificial therapeutic abortion, quite apart from criminal abortion, must be as far as possible discontinued. Bumm, in the large material available in the University Clinic at Berlin, has only had occasion to practice therapeutic abortion about 12 times per year. In the author's clinic during the past six years, in a total of 5,500 cases, he has had to perform abortion only thirty-one times. Bumm also mentions that of 202 cases sent to the clinic for therapeutic abortion he only performed it in 59 cases. In the years 1910 to 1915, 134 women came to the author's clinic for therapeutic abortion as follows: (1) of their own accord, 55; (2) sent by physicians, 72; (3) sent from the intern clinic, 4; (4) sent from the obstetric department, 3. Of these only thirty had to be operated upon.

It may be inferred from this that at least two thirds of the therapeutic abortions performed by private physicians are not indicated and are unnecessary when the cases are dealt with by skilled obstetricians. This is the evil practice that must be suppressed. On no account should therapeutic abortion be included among legitimate obstetrical operations.

There is scarcely any agreement among competent physicians as to the causes which are strictly indicative of induced abortion. In every case where an abortion is considered a consultation should be held with a special internist who would not be concerned with the pregnancy but with the absolute condition of the woman as to concomitant disease. The author recognizes that 80 per cent. of abortions have their initiative from the woman herself and discusses this phase of the question from the political and professional viewpoints.—(*S. G. O.*)

A Case of Complete Central Placenta Praevia.

De Bellard's case of central placenta praevia occurred in a woman of 22, a II-para. (*Gac. méd. de Caracas*, 1916.) She had had several hemorrhages during the later months of her pregnancy. In the early part of the ninth month, examination by the author revealed distinctly the existence of a spongy mass between the presenting fœtal part and the examining finger, which led to the diagnosis of complete placenta prævia. As the woman was in good condition no intervention was made. When about to full term she was suddenly seized with a very severe hemorrhage and labor was induced. The fœtus was easily delivered by version by the Braxton-Hicks method, but was asphyxiated and could not be revived.

The placenta weighed 564 grams. The cord was inserted about 4 cm. from the placentary edge. The perforation was situated about 7 cm. from the placental edge in a direction opposite to that of the insertion of the umbilical cord. There was complete laceration at the site of the perforation extending from it to the placental margin.—(*Int. Abst. Surg.*)

Scopolamin and Morphin in Labor.

R. W. Johnstone, of Edinburgh, points out two points worthy of rememberance. The first is that the aim of the treatment is not anesthesia, nor even analgesia in the first place, but amnesia. If the injections result in the patient appearing to suffer no pain during the uterine contractions, then she is definitely over-dosed. The patient ought to groan and move herself a little during each pain, and in the intervals fall into a sleep. During the pains she may answer questions, or complain of the suffering in perfectly coherent language, and ask for water, which should be given her. But in spite of this apparent consciousness of the sufferings, she will be found to have afterwards little or no recollection of it.

Secondly, the babies after scopolamin-morphin treatment are usually a little sleepy, and rarely cry much for the first twenty-four hours. But, provided the child is breathing regularly, even though slowly, there is no danger. If its color is bad, then the usual artificial respiration is required, and a warm bath is most helpful.

In all probability a slightly cyanosed baby would come right in due course without any treatment at all. But while he has never had the courage to act upon this opinion, Johnstone thinks there is some unnecessary nervousness about the minor degrees of cyanosis and oligopnœa occasionally experienced with this treatment.—(*Practitioner*, April, 1917.)

Bacteria in the Newborn Causing Septic Infection.

Hymanson and Hertz examined 42 newborn infants to determine the presence of bacteria in the cavities of the body. The results were positive in 16, and negative in 26. In only four cases were the same organisms found in the body of the mother. There is little evidence of infection of the infant's mouth on the first day after its birth, but on subsequent days infected bacteria grow and flourish and staphylococci predominates. It is not difficult to understand how such infection can occur in view of the presence of bacteria in the mother's birth canal and the frequent manipulation of the child's mouth in cleansing before and after nursing.—(*Am. Jour. Obst.*, No. 4, 1917.)

Observation of a Case of Double Uterus.

The case of double uterus reported by Maldonado Moreno (*Semana méd.*, 1917, xxiv, 487) was discovered during the expulsive period of labor. Vaginal examination disclosed a vaginal septum which divided the vagina sagitally in two parts. The right orifice contained the deeply engaged foetal head. The septum obstructed the progress of the labor and the child was delivered by forceps.

Further examination showed the existence of two distinctly separate complete uteri, each having its own vaginal passage separated by the thick septum. It was observed that the nongravid uterus accompanied the uterus in the state of gestation in its plastic and dynamic phenomena.—(*Int. Abst. Surg.*)

Lane's kink is characterized by a history of chronicity, periodic attacks of partial obstruction, associated with colicy pains and tenderness just to the right of and below the umbilicus. *X*-ray examination will reveal the obstruction.

Genito-Urinary Surgery

The War and Venereal Diseases.

E. Kilbourne Tullidge, U. S. N., thinks there is no doubt that syphilis, gonorrhea, and chancroid never would have obtained the proper and necessary publicity were it not for the fact that this great war is causing these diseases to spread throughout the various countries involved with greater rapidity than normally. However, the worst is yet to come. What may seem a menace to-day in Europe will develop to become a colossal scourge in our own country when the men come back from the front. E. Gaucher in the *Bulletin de l'Académie de Médecine* of Paris emphasizes the extraordinary prevalence of gonorrhea and syphilis in both men and women since the beginning of the war, and states that he has been appalled at the ignorance of the dangers of these conditions, revealed by inquiry among the young men of the army and navy. We have only to review the surprising statistics compiled by Gerrish, who in 1911 estimated that 10 per cent. of the population of New York City were syphilitic and that over 18 per cent. of the people of the United States showed signs of the disease, to realize one of the vast undertakings in the hands of the medical profession upon our entrance into the war. Today syphilis has increased, probably doubled, certainly not diminished, as no precautions have been officially taken to check it. In the army not long ago Bartlett found 10 per cent. of one command infected, and Archibald Church, estimated that there were twenty million syphilitics in the United States, with an expenditure of over eight millions for the care of luetic insane alone. British authorities state that venereal diseases are the cause of more hospital admissions among the soldiers than any other disease or group of related diseases, causing 38.8 per cent. of the total inefficiency of the British armies in France and one-third of all illness of the British navy, both at home and abroad during 1911. V. L. Kellogg states that in 1910 the British Naval Force included 113,530 men, of whom nearly 15,000 were ill from venereal diseases and that hospital admissions of soldiers for these diseases averaged more than 1 case for every 5 men in that branch of service.

Examination of over six thousand men, under the author's care in the Austro-Hungarian army revealed conditions that proved of startling significance. Primary lesions were found upon almost every part of the body, the palms of the hands and soles of the feet not excepted. Over 60 per cent. of the discoverable lesions, the diagnosis of which was substantiated by a Wassermann reaction, had not been reported nor had an application been made for treatment.

The best results may be obtained in the service by, first, careful supervision and frequent inspection of the men with the establishment of a severe penalty for failure to administer the prophylactic provided; secondly, providing carefully inspected, restricted districts or houses of prostitution conducted especially for the men in the service under military supervision. This practice is successfully employed in Italy, Germany, Austria, and but lately in France and England with surprisingly satisfactory results. With the establishment of these houses during the course of venereal inspection of the men, which was held in the German army religiously every two weeks, the appearance of any veneareal disease could be traced directly to the seat of infection and the prostitute placed under arrest and sent to a government hospital, where she remained until pronounced cured. For those living at sea on board ship the establishment of such districts or houses would prove a godsend for the men given liberty on shore, and would with the prophylactic almost eradicate the disease from the naval service.

The following are the details of the newly enforced scheme of the British Government toward this end.

Hospitals are established, especially at naval stations or bases, where treatment is carried out under the direction of a trained medical officer. The clinic is opened at least three afternoons and evenings each week and a stated time designated for the treatment of males and females. There is provision for six beds for each sex and the treatment will be absolutely free to every patient without distinction. Laboratory facilities are installed for the examination of all specimens and the performance of the Wassermann test. The station with its equipment is open for the use of all physicians in the district without cost. Salvarsan, neosalvarsan, and mercurial preparations are furnished for the use of all physicians gratis, and the strictest confidence is observed in regard to all persons receiving treatment.

Such clinics could be established in this country under State or municipal control, not only in the large centers, but in the small ones, as well, and instruction given at them to the practitioner, student, and public at large in the care and treatment of venereal diseases.

Two prophylactic treatments for these diseases have received wide attention and consideration. The former Army "K" packet, containing a solution of 20 per cent. protargol or 10 per cent, argyrol, a medicine dropper or syringe, and a vial of 30 per cent. calomel ointment, was effective when used not only as a prophylactic, but within two hours after intercourse. In a section of over seventeen hundred militiamen who received this treatment properly on the border during the last mobilization, thirty-eight developed venereal disease. Ten were primary luetic sores, ten chancroids, and the remaining eighteen gonorrhea which was complicated in seven cases with one of the former infections. With these results this treatment could hardly be called successful and the large percentage of infections resulted either because of the failure of the men to apply for treatment within the prescribed time after intercourse or because of the failure of the ointment to come up to its declared standard of efficiency. With these possibilities in view and with the idea of providing for the men in the naval service who are unable to obtain treatment within the prescribed two-hour period necessary for proper results, Surgeon Robert A. Bauchman, U. S. N., after an exhaustive investigation and experimentation, both at home and abroad, prepared an ointment similar to Metchnikoff's preparation, but which Metchnikoff himself declared to be a great improvement over his own original preparation in the treatment of syphilis. This ointment, which contains 33 per cent. calomel reinforced by 1 per cent. trikresol, he placed in a collapsible tube carefully prepared and enameled throughout inside to prevent a degeneration of the mercurial substance by contact with the metal of the tube itself. A soft rubber tapering nozzle one and one-half inches long, which may be introduced well up into the meatus beyond any possible area of infection, covers its mouth. This preparation he claims is most efficacious. It is smaller in bulk, more compact, and therefore more easily handled. If carried upon the person at all times and properly used both before and immediately after intercourse, or within an hour, it has decided advantages over all other treatment.—(*Med. Rec.*, Sept. 22, 1917)

A New Method of Fixing the Testicle in Orchidopexy

The first stage of Milon's technique of fixation of the testicle in orchidopexy follows the customary procedure of opening the inguinal canal, incising the aponeurosis of the external oblique, and exposing the testicle (*Rev. gén. de clin. et de thérap.*, 1917, xxxi, 134). The cord and spermatic vessels are isolated from adhesions and freed along their length and the testicle placed in its proper location. The anterior wall of the inguinal canal is then closed by first suturing the upper half only of the sectioned aponeurosis. On each lip of the lower half of this section a strip, 4 to 5 mm. wide, is cut, free at the upper end and adherent at the lower end.

The two strips are reversed and drawn down by their upper free end toward the scrotal orifice. Suture of the edges of the aponeurosis is then completed and the anterior wall of the inguinal canal remade and closed to its lower orifice. The two strips are then intercrossed which brings the external toward the postero-internal side and the internal strip to the postero-external side. They are then sutured in this position, passing straddled over the cord, above which they form a bridge the arch of which is lax enough to allow free passage to the funiculus, but is sufficiently tight to prevent upward evasion of the testicle.

This procedure has given very excellent results without any ulterior disadvantage.—(*S. G. & O.*)

Prostatic Hypertrophy; Report of 400 Prostatectomies.

B. S. Dunn of Paris, formerly of New York, describes the routine method of preparation of cases, the technic of operation, and the post-operative care followed by Pauchet, in 400 suprapubic prostatectomies. To the character of the preliminary treatment is attributed the great reduction in the mortality. The first 100 cases showed a mortality of 10 per cent., the second 8.1 per cent., the third 6.5 per cent., and the fourth 4 per cent.

The preparatory treatment is directed particularly toward avoiding such post-operative complications as uraemia, infection, pulmonary edema, pelvic cellulitis, infection of the prostatic cavity, phlebitis and embolism. Considerable significance is paid by Pauchet to his first impression of the clinical risk. If the patient is a thin, wiry subject with the appearance of good resistance he does not hesitate to operate at once. Of

particular importance in the preparatory treatment are held forced ingestion of fluids, often with the addition of bicarbonate of soda, an exclusive fruit and green vegetable diet, the institution of a general routine massage treatment, and respiratory gymnastics. These respiratory exercises are regarded as of value for the prevention of subsequent pulmonary complications. For the estimation of renal function, Pauchet employs methylene blue and Ambard's constant.

Another factor which Pauchet regards as of value in lowering his mortality is the adoption of the so-called "two-time" technic in selected cases. The patient is submitted to the regulation of fruits, food and exercise, as described, and in addition the bladder is opened and drained for from one to six months before prostatectomy is performed. This "two-time" procedure he applies to the following classes of cases:

1. Cases with incontinence and polyuria who have distended bladders.
2. Cases with infected urines.
3. Cases with marked renal insufficiency.
4. Cases in which catheterization has been difficult or painful.
5. Cases of marked clinical risk due to cardiac insufficiency, diabetes, obesity, etc.

Among the points in operative technic, the following details are emphasized:

1. Do not separate the bladder wall from the cavity of Retzius. Trauma to this region causes pelvic cellulitis.
2. A complete clean enucleation of the gland must be effected and the cavity left absolutely cleared of all debris. Pauchet considers that in an incomplete or poorly performed operation lies the greate stdangerofinfection.mC shrdlu cmfwyp shrd lies the greatest danger of infection.
3. The mucous membrane of the bladder and urethra should be severed as cleanly and neatly as possible in order to guard against subsequent stricture.
4. Pauchet considers that it is necessary to firmly pack the prostatic cavity with a special long single gauze in at least one-third of the cases. This packing is extremely painful and requires morphin.
5. In feeble subjects Pauchet considers it advisable to sever the vas deferens as a prophylaxis against the development of epididymitis, which in these feeble men often means a fatal termination.

For some time transsacral regional anesthesia has been practiced by Pauchet to the exclusion of all general anesthesia in thin subjects, a presacral in fat ones. Novocain-adrenalin or novocain-suprarenin are used.—(*Am. Med.*, July, 1917.)

Prostatectomy.

Results in prostatectomy are perhaps more dependent on careful selection of cases than for many other operations, says J. B. Deaver of Philadelphia. Infection is often present together with kidney, myocardial and vascular complications, and the general vitality of the patient is often at its ebb, so that all the usual functional tests, phenosulphonephthalein, phthalein, blood urea and indigo-carmin should be made and treatment instituted to improve function and general conditions before attempting operation on the average prostatic. The cases fall into three general groups with gradations from one group into the other, each of which, however, should be considered a clinical entity and treated as such.

The first group comprises the early mild cases, in which symptoms are not exaggerated and the general condition is good. Operation in these cases need not be delayed beyond the necessary time for making the routine functional tests, and the effects, if any, of cystoscopic examinations have worn off.

The second group represents a later stage of prostatism, with or without marked systemic changes, the most prominent symptoms of which are frequency of urination, dysuria and hematuria. Although fair operative risks, these cases improve so much under pre-operative treatment as to materially improve operative prognosis. Keeping the bladder empty by intermittent catheterization usually suffices to relieve back pressure on the kidney in this type of case, and there is soon an increase of phthalein output. Permanent catheterization has been abandoned in favor of suprapubic cystostomy, except for very severe cases in which this simple procedure is contra-indicated, or in certain instances in which it is desirable to obtain gradual reduction of back pressure on the kidneys, and improvement in coexisting cardiac conditions.

In the third group, fortunately comprising only a minority of cases, the spread of infection has produced most distressing symptoms involving the entire urinary tract. The obstruction at the bladder neck being due either to stricture, often inflammatory in origin, or to an adenomatous mass of the horse-collar or ball-valve type. There is little residual urine in the bladder, instrumentation is not well tolerated being often complicated by epididymitis, and the symptoms of hematuria, urinary distress and toxemia have reduced vitality to a very low ebb. These are not only poor operative risks, but prostatectomy often fails to relieve the symptoms. Prolonged pre-operative treatment is essential, although it sometimes becomes necessary to drain the bladder when under other circumstances prolonged treatment would be desirable. The mortality of this group is high.

As to operation, the two-stage operation is used where catheterization fails promptly to relieve back pressure on the kidneys and wherever active urinary infections exists, also where there is a doubt as to the ability of the patient to withstand a suprapubic prostatectomy. For the preliminary cystostomy, as well as for the final enucleation, ether or gas oxygen anesthesia, preferably the former, or in cases with very high blood-pressure, chloroform is better. Stress is laid on proper placing and testing of the drainage tube in order to secure perfect siphonage. This preliminary drainage of the bladder is continued usually for two weeks or until tests indicate a maximum physical efficiency. Enucleation is then proceeded with.

Where the most prominent nodules project into the urethra, the Squier method of dissection anteriorly through the roof of the prostatic urethra is the chosen one, as by this means there is little danger of injuring the sphincter muscle. The Freyer method of attack from the vesical aspect is the method of choice where the enlarged prostate projects into the bladder, and the sphincter having been pushed aside, there is little or no danger of injuring it. In many cases Deaver makes a circular incision through the mucous membrane and the overlying prostatic sheath around the vesical orifice of the urethra and carries the enucleation through this gutter, which, when completed, does not cause any irregularities of the mucous membrane such as have been known to cause subsequent obstruction and to require removal in order to restore function.

Profuse hemorrhage is controlled by enlarging the wound so as to give free access to the prostatic bed, placing a purse string or overrunning suture of plain catgut in the mucous membrane forming the margins of the cavity, and firmly packing the latter with a single strip of gauze, the free end of which projects through the parietal incision through the bladder wall alongside the drainage tube, after which the suture is drawn taut and tied.

Perineal prostatectomy is appropriate for cases in which obstruction is due to sclerotic conditions at the vesical neck; but the suprapubic approach is preferable where it is necessary to remove an obstructing bar, or where sclerosis of the bladder orifice indicates the excision of a wedge from one or more points in its circumference. In the hands of the expert, the one operation is as safe as the other, but to the less experienced the suprapubic route is the safer, since it is rarely attended with the complications, such as fistula, incontinence and failure to relieve the obstruction at the vesical outlet, so frequently accompanying the perineal operation.—(*Transactions Am. Surg. Assn.*, 1917.)

The Verumontanum, With Special Reference to the Sinus Pocularis.

A. G. Rytina of Johns Hopkins Hospital studied carefully serial sections of the verumontanum and its immediate neighborhood. He found that the verumontanum is an elevation formed by the upward projection of the sinus pocularis covered by the mucous membrane of the posterior urethra. The verumontanum is made up almost entirely of the sinus pocularis together with the ejaculatory ducts and occasionally a few prostatic ducts. It is not a cavernous structure, indeed the blood supply is not any greater than the surrounding tissue, and therefore its function cannot be of an erectile kind. The ejaculatory ducts may open into the sinus pocularis, as this occurred in one of Rytina's cases. The author agrees with Walker as to the physiology of the verumontanum and sinus pocularis, viz. that the veru serves to elevate the ejaculatory ducts to a central position in the urethra, where the spermatozoa are quickly mixed with the numerous jets of prostatic secretion, and that the sinus provides a secretion helping to make up the semen—but adds that complete excision of both structures does not interfere with normal sexual function.—(*Jour. Urology*, No. 2, 1917.)

Besner believes that tubercular ulcer (anal) in phthisical patients is secondary to their general infection, while tubercular lesions elsewhere on the skin are the result of external infection.

Transverse Colostomy.

P. Lockhart Mummery, of London, says: The best incision is a vertical one over the middle of the left rectus muscle, the upper limit being at or just above the umbilical level. The ideal length of the incision is 2 inches, but in practice this must depend upon circumstances, such as the amount of fat and the thickness of the muscle. It should, however, always be as short as possible. The anterior sheath of the rectus having been divided, the fibres of this muscle are separated by blunt dissection and the abdomen opened. The great omentum is then found and drawn out of the incision until the transverse colon is met with. The transverse colon must be investigated to see what length is available. If it is found that there is plenty of bowel and that it can be brought up to the surface without undue traction on the stomach, a part of the transverse colon is selected as far up towards the splenic flexure as is compatible with a reasonable freedom from tension. The fingers of the left hand are then passed under the great omentum, and the selected portion of transverse colon is pushed up with the fingers through the omentum overlying it. With a pair of blunt dissection forceps held in the right hand, a hole is then scratched in the great omentum till the colon itself is exposed, care being taken to avoid any obvious blood-vessels. When a sufficiently large hole has been made, the colon is pushed through it until a glass rod can be passed beneath the bowel, and a piece of rubber tubing of suitable size is passed over each end of the glass rod so as to retain it in position. The whole of the omentum is returned into the abdominal cavity, leaving the selected knuckle of colon completely surrounded by omentum which occupies its normal position under the abdominal wall. The ends of the skin incision are now closed by stitches in the usual way. The glass rod, instead of lying across the wound as in sigmoid colostomy, will lie up and down it. An obvious suggestion is to make the skin incision transversely, so that the glass rod does not lie on the wound. The objection to this is that a transverse incision cannot be extended if an abnormality is discovered, and no harm results from the presence of the glass rod over the wound.

After-Treatment.—After transverse colostomy, the bowel usually has to be opened much earlier than with sigmoid colostomy, for symptoms of obstruction tend to come on quickly, and it is generally advisable to open the bowel within thirty-six hours. This is of little consequence, for the omental shield completely protects the abdominal cavity from any fear of infection, even if the wound should become septic, which is very seldom the case. Nine days after the operation the glass rod is removed, and one blade of a pair of scissors is passed under the bowel in the track of the glass rod, and the bowel cut completely in half. At the same time any redundant bowel outside the skin is cut away, bleeding points, which are often numerous, being secured with catgut stitches. Stitching is better than attempting to pick up the bleeding points with forceps, for the tissues do not hold forceps well. It is very important to cut the colon completely in half, for this arrests the peristaltic wave at the colostomy opening and prevents it continuing down into the distal gut. A properly completed colostomy opening should, after healing, show no mucous membrane projecting above the skin surface, and the opening into the colon should only just admit the finger.

The period of recumbency after an operation for transverse colostomy must depend upon circumstances. If only a small incision has been made and the patient is otherwise a healthy subject, there is no necessity for him to be kept in bed for more than ten or twelve days. On the other hand, if the patient is very stout, a fact which necessitates a large incision, or old and weakly, in which case healing will probably be slow, a longer period is necessary.

Colostomy Belts.—Many different kinds of belts have been invented, and I have had patients who have tried all of them. Provided the actions of the bowel can be properly regulated, which is the case with the majority of patients, by far the best apparatus is a simple belt with an india rubber section where it passes over the colostomy opening. A pad of wool is worn under this, and kept in place by the belt. No other apparatus at all is used, and it is very much the best arrangement in most cases. Some patients prefer to have a celluloid cup over the colostomy opening, but this should not be incorporated in the belt, but separate from it. If no regularity in the actions of the bowel can be established, some form of apparatus with a receptacle for the evacuations must be worn.—(*Practitioner*, Aug., 1917.)

Pain, exhaustion, a feeling of fainting, after the stool, is concomitant of pronounced atony of the colon, and ptosis.—(J. M. Bell, ***Med. Herald.***)

Technique of Methodical Extirpation of the Larynx Under Local Anesthesia.

In 1910 Sebileau published his technique for extirpation of the larynx under general anesthesia. He now describes the same operation done under local anesthesia. (*Bull. et mém. Soc. de chir. de Par.*, 1917, xliii, 473.)

The line of incision is first traced on the surface. The teguments are then anesthetized by current methods. All accessible parts of the laryngotracheal tract, i.e., its anterior and lateral faces from the hyoid bone to the manubrium, are suffused with a 1:200 solution of 20 ccm. of novocain with adrenalin added.

In a laryngectomy with closed trachea there is as a general rule no trouble as regards the patient's respiration. In the case of an open trachea Sebileau first removes the cannula carried by the patient; then anesthetizes the trachea with cocain solution 1:10. A long rubber tube as thick as possible is introduced into the tracheal opening and is pushed for some centimeters into the respiratory tract. Then it is fixed by a few sutures to the skin surrounding the tracheal orifice. The vertical and parallel incisions, following the tracheal conduit and on either side about 3 cm. from the sagittal line, extend from the hyoid bone to the suprasternal hollow and form thus a long and narrow rectangular strip in front of the laryngeal conduit. This rectangle is dissected as far as the limits of the tracheal orifice, there being little hemorrhage as the region is bare of vessels. The strip of skin which is only adherent at the tracheal opening is then lifted up and wrapped tightly about the rubber tube and the edges hermetically sutured along its length so that no blood can enter the trachea. The methodical extirpation of the larynx is then proceeded with.

The cutaneous resection facilitates the laryngeal resection and there is usually sufficient material left to suture over the operative field at the end of the operation, because the removal of the larynx materially reduces the surface to be covered.

In the extirpation of the larynx, the author follows Perier's method as modified by him and described in 1910.—(*S. G. & O.*)

Nature and Control of Hemorrhage in Nasopharyngeal Operations.

J. Weinstein says the preventive methods consist of: 1. A careful study of the general condition of the patient so as to reveal any constitutional conditions favoring a hemorrhage from the much feared hemophilia to diseased kidneys with consequent high blood-pressure.

2. Such mastery of technique as shall result in the choice of the method best adapted to the individual case, including a study of the local anatomical situation as well as choice of a proper anesthesia.

Surgical methods advised in cases of postoperative hemorrhage following operation upon the tonsils and lateral wall of the pharynx are:

1. Application of Mikulicz's compression forceps.
2. Sewing together of palatal arches.
3. Compression of common carotid artery.
4. Ligation of common carotid artery or its branches.

Based upon the commonly accepted causes of hemorrhage, viz, high blood-pressure, persistent vasodilatation, and delayed blood-clotting, the therapeutic measures employed in the control of hemorrhages are of three kinds:

1. Those equalizing the circulation and lessening the intravascular pressure at the bleeding point.
2. Those contracting the vessel itself.
3. Those decreasing the coagulation time of blood.

The author has had extremely gratifying results with the hypodermatic injection of one-half grain of emetin. This is done as a matter of routine, since his tests showed that fifteen minutes after injection, the bleeding time was reduced by one-third. Pituitrin gave about the same results; likewise coagulin cila, thromboplastin, and coagulose.—(*The Laryngoscope.*)

The Results of Dislocation of the Shoulder and Its After-Treatment.

Korteweg reviews the cases of dislocation of the shoulder which came under the observation of the government insurance department between the years 1904 and 1912 (*Zentrabl. f. chir.*, 1916, No. 46, 926). In regard to recovery he divides them into quick cures—1 to 20 days, usual—21 to 35 days, prolonged—36 to 100 days; those which have not fully recovered their function after 100 days he considers bad cases. On account of the compensating ability of the body to take care of lesser grades of functional defect there is frequently a 20 per cent. difference of opinion in regard to estimating the

liability and compensation. He therefore disregards all cases which have only a liability of 10 to 20 per cent. if the ability to work is not reduced.

The treatment employed after the reposition is also important: immobilization and massage or immediate active and passive motion. Rest leads to organization of the intra and extracapsular functional disturbance. Massage in conjunction with rest can again lead to tears in the soft friable tissue and produce new bleeding and pain which necessitates more immobilization and its consequences. This treatment followed for many years must therefore be superseded by an active mobility treatment, which according to Marbaix produces much better results.

The author reviews the 845 cases in regard to all possible causes or influences, i. e., whether right or left-sided, direct or indirect dislocation, according to age, whether in city or country, in what period of industrial control, severity of the lesion, and from this hopes to find influences which may have a bearing upon the lesion and the result obtained.

The author's conclusions are: Indirect dislocations are as a rule mild cases and more frequently left-sided. Right-sided dislocations heal faster. This is not accidental. Fractures of the right upper extremity heal faster than those of the left side with the exception of the clavicle and fingers; whereas it seems that fractures of the left lower extremity obtain their complete function faster than those of the right side, and this is definitely proven for the bones of the feet. He explains this as follows: the right arm is the more active; there is a great desire to employ the right arm as soon as possible, yet it is necessary that the clavicle as a part of the arm carrying shoulder girdle obtain its full weight carrying ability before the arm is moved too freely. And these factors play an important part on the right side. The severity of the trauma is not as important as the manner of it; vessel and nerve complications are less frequent than supposed.

For the diagnosis of a nerve paralysis the author demands the presence of disturbances of sensation and the complete or partial reaction of degeneration. The fracture of the greater tuberosity is likewise rare but if present immediate extension with complete abduction is necessary. The so-called complications of dislocation of the shoulder, i. e., stiff shoulder, decided muscular atrophy, even of the entire arm, with bluish discoloration and thickening of the skin is the result of blood and lymph stasis and therefore should be prevented if possible. This is absolutely necessary as 10 per cent. of all shoulder dislocations receive compensation and a further 10 per cent. are able to resume their labor under considerable difficulty.

The results in Holland with the moderate duration of convalescence, 55 days, due to the Marbaix method, and complete recovery of some cases in 18 days are better than those obtained in the large German clinics. On that account the author is decidedly in favor of the Marbaix method. The active motion instituted immediately after the reposition becomes more painless each time and favors absorption. Inflammation is prevented and perfect function is obtained before atrophy can set in. Movements with the aid of the healthy arm bar exercises, especially for abduction; lifting of a sand bag with the aid of a pulley, and like exercises act very favorably. The day after the injury and reposition work should be commenced. but of course in a very mild form. After eight days turning exercises during leisure hours are instituted. Psychic factors, initiated by the physician and directed into the proper channels, also play an important part. The article, everywhere critical and exact, presents a multitude of interesting facts and the appearance of further articles are awaited with interest.—(*S. G. & O.*, July, 1917.)

Contracted Bladder.

After mentioning the various causes of contracted bladder, its clinical symptoms and the difficulties of accurately diagnosing the causal lesions when the cystoscope is unavailable, and reviewing the treatment, Martin Krotoszyner, San Francisco, concludes his article as follows: "1. The congenital and so-called idiopathic contracted bladder is rare and practically unimportant. 2. Bladder contraction, in the majority of instances, is due to extravesical causes (pyonephrosis, etc.) 3. Of the utmost practical importance is the tuberculous scar tissue bladder, secondary to renal tuberculosis. 4. The clinical diagnosis of contracted bladder is comparatively easy, while recognition of its underlying causes is very difficult and, as a rule, feasible only on the basis of comparative examination of renal urines, obtained by bilateral ureteral catheterization. 5. Successful cystoscopic exploitation of contracted bladders below 50 cc. capacity is almost always feasible, provided sufficient time, modern urologic equipment, cystoscopic experience and skill, and co-operation of the patient are available."

Diagnosis and Treatment

The Relation of Lymphatic to Pulmonary Tuberculosis.

Dr. F. Harbitz, professor of pathology at the University of Christiana, has lately published his observations on the post-mortem material passing through his hands in the period 1904-15. His earlier work, published in 1905, on the frequency, localization, and modes of dissemination of tuberculosis, has been supplemented and criticised in the light of his later investigations, and the result is a valuable contribution to some of the most vexed problems of tuberculosis. The analysis of this work, contributed by Dr. K. F. Andvord in *Norsk Magasin for Laegevidenskaben* for July, shows that among the 2,906 necropsies in the years 1904-15 there were 431 deaths from tuberculosis, the relative mortality from which was, therefore. 14.8 per cent. Among children under 15 years the tuberculosis mortality was 19 per cent., among adults only 14 per cent. There were 203 cases of advanced tuberculosis of the lymphatics, including 61 of generalized lymphatic tuberculosis (32 adults, 29 children).

Dr. Harbitz has come to the conclusion that, as far as tuberculosis of the lymphatics is concerned, the disease usually spreads from one group of glands to another through the lymphatic system by a continuous process. Spread of infection by more casual and intermittent means is, he believes, comparatively rare; but he suggests that hematogenous infection must be reckoned with when the first infection of a lymphatic gland is traced to childhood. According to his figures, it is a discouraging fact that 40 per cent. of all the cases of generalized lymphatic tuberculosis in adults terminated fatally in chronic pulmonary tuberculosis. And in this form of pulmonary tuberculosis the disease seldom originated as a primary infection of the lungs by inhalation, but as a secondary, hematogenous infection from the lymphatic glands. Dr. Harbitz's investigations also afford a fairly reliable pathological, anatomical basis for the hypothesis that the pulmonary tuberculosis of adults is often a late sequel to infection in childhood. In 39 out of 219 cases of pulmonary tuberculosis (18 per cent.) in adults, he says, it was possible to demonstrate the presence of tuberculosis from earlier years, in most cases certainly from childhood. These old tuberculous lesions may have been, indeed possibly were, the source of the subsequent pulmonary tuberculosis. In other words, if his conclusions are correct, the pulmonary tuberculosis was anautogenous or endogenous re-infection. Tillisch, of Grefsen, has found among his patients suffering from pulmonary tuberculosis a history of exposure to infection in infancy in 18.5 per cent. That he should have arrived at practically the same figure as Dr. Harbitz is all the more striking as their methods were totally different, and both were bound to understate the case for infection in childhood. The tuberculin test, it may be noted, shows a far higher ratio of infection in childhood than 18 per cent.—(*Lancet*, Aug. 4, 1917.)

The Value of Genito-Urinary Antiseptics.

We have often called attention in these pages to the fact that unless a drug has a particular affinity for some form of parasitic protoplasm it cannot destroy this protoplasm without doing damage to the more highly organized tissues of the human being. It is this fact which stands in the way of the administration of so-called antiseptics in the treatment of many infectious diseases, and in the infections of the genito-urinary tract it has been urgently desired that something might be found which, when taken by the mouth, would be eliminated by the kidneys and possess active antiseptic power. While the results along this line have been better than in the case of infections in other parts of the body, they have, nevertheless, been disappointing because this failure does not alone lie in the reasons just given, but also depends to some extent upon the pathway of infection. When it is through the blood there is a continual reinfection taking place in the genito-urinary tract, and this is possibly also true when the infection is from below. One of the reasons which have been advanced, however, to throw doubt upon infection from below upwards has been that it seemed unlikely that microörganisms would find their way up the ureter against the stream of urine into the pelvis of the kidney.

In this connection an interesting contribution to the *Journal of Medical Research* has been made by Eisendrath and Schultz, who have demonstrated the presence of an anastomosing network of lymphatics in the wall of the bladder and of the ureter, communicating above with a similar lymphatic network in the

renal pelvis and parenchyma. At its lower end this system communicates also with the lymphatics of the pelvic structures, in both the male and female. Other conclusions reached by these authors are as follows:

Infections of the bladder or lower ureter may reach the renal pelvis or the kidney, either by way of the lumen of the urinary tract or by way of the mural lymphatics.

Experimental and clinical evidence indicates that almost complete obstruction to the free passage of urine is necessary for the ascent of infection by way of the lumen of the urinary tract.

Experimentally they have shown that infection, set up by the simple introduction of bacteria into the bladder without injury or without obstruction, may pass upward by means of the interstitial lymphatics of the ureter.

The degree of involvement following the introduction of bacteria into the bladder depends upon the virulence of the organism and upon the susceptibility of the animal. The subsequent tissue reaction may remain limited to the bladder and ureter, it may pass upward to the tissues of the renal pelvis, or even the parenchyma of the kidney itself may become involved.

When the kidney tissue is involved in ascending infection brought about experimentally, as described, the path of travel is from the subepithelial tissues of the pelvis to the kidney by way of the intertubular and perivascular lymphatics.

From the kidney the perirenal tissues may become involved through the capsular lymphatics, which anastomose with those of the cortex.

The experimental evidence indicates that, in cases of pyelitis and pyelonephritis in the human, secondary to infection of the bladder, the lymphatics constitute the most important course of upward travel of the infection, especially in those cases in which there is no hindrance to the urinary outflow.

Pyelitis and pyelonephritis, not secondary to cystitis, may also be the result of lymphatic transport of infection from the pelvic organs in the male and female, and from the lower intestinal tract.

The extension of infection by these lymphatics is another adequate explanation for the failure to do good of antiseptics administered by the mouth for elimination by the kidney.—(*Ther. Gaz.*, July, 1915.)

A New Instrument for Percussion and Auscultation.

In the continual struggle for accuracy in methods of physical diagnosis, Tornai (*Wien. klin. Wochn.*, 1916, xxix, 1625) describes an instrument which he considers a distinct advance in the field of auscultation and percussion. It is a modification of an earlier apparatus which he described in connection with "phonoscopic percussion" in 1912, and which he called at that time the "phonoscope." The new instrument is called the "novoscope," and consists essentially of a single-stemmed stethoscope bell or chest piece connected by a short piece of stethoscope tubing to a metal Y tube, the two arms of the Y being connected with the ears by rubber tubing and vulcanite olives, or by tubing and the ordinary metal stethoscope ear pieces. The metal Y is connected to a metal head piece, such as is used with head mirrors, by means of an aluminum rod, which has a joint in its center permitting movement of the distal half of the rod upward through 180° in the vertical plane. The connection of the rod to the head band is made by a ball and socket joint which can be locked by a thumbscrew. With a head piece adjusted and the ear pieces in position, locking the ball and socket joint with the rod extended in front of the examiner's head permits him to percuss, with the stethoscope bell just above the percussing fingers, and the examiner listens to the percussion sounds through the medium of the stethoscope. Loosening of the ball and socket joint on the head piece converts the instrument into an easily usable stethoscope for ausculation. The writer contends that percussion tones are heard much better by this method, which enables finer distinctions to be made in the pitch and quality of the percussion notes, so that greater accuracy is secured in the percussion of the chest and its contents. He states that very light percussion strokes must be used—preferably the so-called "threshold percussion"—and the patient examined in a very quiet room. The results obtained by this method of percussion in his hands are exceedingly accurate. The instrument is small and can be folded to carry in the pocket, and is so simple in design that any clever mechanic can construct one in a very short time.—(*American Journal Medical Science.*)

It is bad form for a man to carefully select his brand of liquor and then feed his children on unpasteurized milk.

Normal Blood-Pressure.

Various tables and formulas have been suggested, of which the following may be given as representative:

Faught suggests that the normal average systolic pressure for a male at the age of twenty be considered 120 mm. and that for every additional two years of life one millimetre be added. Taking the figures thus obtained, a variation of 17 mm. above and below the average may be regarded as permissible.

Fisher gives the following table of average systolic pressures for the different age periods and allows a variation of about 12 mm. to each direction:

Age periods	Average
15-19 years	120
20-24 years	122
25-29 years	123
30-34 years	124
35-39 years	126
40-44 years	128
45-49 years	130
50-54 years	132
55-59 years	134
60-64 years	135
65 years and over	136

—(*Dominion Medical Monthly.*)

Nasal Antisepsis.

The discovery of an effective nasal antiseptic is a matter of interest to every one who is liable to the common infectious cold, but its importance has been greatly increased since it has been shown to be, at the least, highly probable that the infection of cerebro-spinal fever dwells in the nose and may be imparted by the nasal secretions, and, moreover, that the infection may be carried by persons who have recovered from the disease and others who have never developed any of its symptoms. In a paper published in the *British Medical Journal* of June 30, Dunham and Dakin described an antiseptic, dichloramine-T, and the preparation from it of an oily solution for spraying the nasal cavities. These observers stated that they had not then been able to treat carriers of cerebro-spinal fever, although they had made encouraging observations on carriers of pneumococci and diphtheria bacilli. The test in the case of cerebro-spinal fever carriers has now been applied with success. Before using the oily solution the nose is cleansed with salt solution or with 0.25 per cent. aqueous chloramine-T solution either by spraying or irigation. When the increased nasal secretion which this causes has subsided, the oily solution of dichloramine-T is applied with an oil atomizer, an endeavor being made to reach all parts of the nasal cavities with an abundant supply of oil. As it is not certain that the oil introduced in this way continues active for more than two hours, it must, if the treatment is to be intensive, be repeated at the end of that interval, and in any case at least four times a day at about equal intervals of time.

Treatment of Gonorrhea by Intra-muscular Injections of Permanganate of Potash.

Mélamet made trial of a general treatment, in view of the fact that gonorrhoea is a general infection. For this purpose he made use of permanganate of potash given by intra-muscular injections. His results are encouraging, for of 31 cases treated 27 were cured.

The patients are given 1 cc. for the first injection, then 2 cc. and 5 cc. on the fourth day, after which the amount is decreased. The solutions used vary in strength according to the degree of obstinacy present. They are: 1.66 m.g. per cc.; 2 m.g. per cc.; and 3.66 m.g. per cc. No local treatment is employed.—(*Journ. des Praticiens*, June 9, 1917.)

Treatment of Chronic Maxillary Sinusitis and the Application of Local Anesthesia.

Ferero reports (*Rep. de med. y cirug.*, Bogotá, 1917, viii, 147) three cases of radical operation for chronic maxillary sinusitis which were done under local anesthesia with highly satisfactory results. Complete anesthesia was obtained from one injection of novocain and the local application of tampons steeped in a 10 per cent. solution of cocain hydrochlorate with some drops of normal adrenalin solution added.—(*S. G. & O.*)

Severe tonsillar hemorrhage, though often termed reactionary or secondary is usually primary.

War Medicine and Surgery

Amputation for Trench Foot.

Lieut.-Col. G. A. Wright refers to the question of amputation in men suffering from gangrene due to trench foot. In a number of cases a decision had to be made as to the best procedure when part, or the whole, of a foot was lost, and a large raw surface remained. Where the bones are seen bare and dead on the face of the stump surrounded by an area of granulating, or cicatrized, soft parts, the author thinks the best practice is to remove only those structures obviously dead, although a secondary operation must of necessity be performed later. If any formal operation is done at once, either too much or too little may be taken away. Moreover, any disturbance of wounded tissues in such patients is apt to be followed by an acute septic process. As little as possible should therefore be done until the extent of actual complete destruction is determined, and the patient's general condition is improved by rest and care. Large and irregular scars may, however, remain. In some cases the amount of destruction of soft tissue leaves no choice, and a formal operation at a higher level is called for. It is too soon to say whether the stump left by "trimming" trench feet will be serviceable, but if a useful foot can be preserved, Professor Wright maintains that it is better to keep it than to sacrifice it for the sake of doing a formal operation. He recognizes the hardship inflicted upon the men by repeated operation, and fears that this cannot always be helped in the case of trench feet.—(*Jour. R. A. M. C.*, No. 2, 1917.

Dakin's "Dichloramin-T" in the Treatment of the Wounds of War.

Capt. Joshua E. Sweet, M. R. C. of United States Army Base Hospital No. 10, France, makes his report to the Medical Research Committee. He says that they have treated some eighty patients with Dakin's "dichloramin-T"; some have been old cases with foreign bodies lying in the bone, and suppuration did not stop until the foreign body was removed. Fresh cases, in which enough integument was left to permit it, have been treated with dichloramine once and immediately closed, and have healed by secondary intention. Sixteen cases, old and fresh, were cultured after treatment with "dichloramin-T" for varying periods, of which eleven gave no growth whatever; of the five in which a growth appeared, four were old cases of deep bone involvement; the only growth was the *Staphylococcus aureus* in four cases and in one case the *pyocyaneus*.

The wounds fill rapidly with granulation tissue of healthy color, which exhibits no tendency to exuberant growth and no tendency to become water-soaked and indolent; the skin edges grow in very rapidly.

These results are no different from those which can be obtained by other methods, and no one would believe them if they were any better. The surgeons of the unit are agreed that the wounds treated by "dichloramin-T" are in every way as satisfactory as they have ever seen under any method; and two of our surgeons have had previous experience in France, while all are surgeons of long experience in civil practice.

The new "dichloramin" solution is made by dissolving the crystals of "dichloramin-T" in chlorinated eucalyptol and then diluting this solution by the addition of chlorinated paraffin oil. It is best applied by an oil spray, an ordinary hard rubber or all-glass atomizer being the most practical method. Metal atomizers are not suitable, since the metal is attacked by the chlorin. This oily solution presents the first great advantage—the dressings do not stick to the wound and the entire act of dressing is relatively painless. The gauze does not have to be separated from the granulations by soaking. It is therefore not even necessary in the average wound to place a waterproof protective covering over the bed-linen while dressing, and the necessity of moving the part or the patient is obviated. The old dressing is simply lifted off, and the wound sprayed; the force of the spray will dislodge sloughs, and the wound is covered with a fresh dressing. It is evident that a very important saving of time results from this simplicity of dressing. One surgeon has repeatedly dressed thirty wounds in ninety minutes—an average of three minutes to each dressing. These figures and the figures to be given later, refer to the acute wards, where the patients are all bed patients.

The solution contains enough available antiseptic so that one dressing every twenty-four hours is ample for large, deep wounds, and one dressing every forty-eight or seventy-two hours is enough for the simple or more superficial wounds. Since the solution contains so much available chlorin and does not have to be renewed every few hours, the use of the Carrel tube is entirely done away with. The oily solution of "dichloramin-T" creeps into all the wound crevices and corners, and it can be readily introduced into sinuses by means of a cotton swab dipped into the solution.

The amount of this new solution needed for wound dressing should be emphasized. At first thought it would seem that a solution containing oil of eucalyptus and paraffin oil would be far too expensive for general use in comparison with eusol. Forty-two wounds were dressed by one surgeon with 35 c.cm.; another surgeon dressed 154 wounds with 115 c.cm. These figures apply to the acute wards, and include many compound fractures and extensive buttock and thigh wounds. The fact that so little fluid has to be used, and that therefore only the wound discharge has to be cared for, results in a tremendous saving of gauze and cotton. Sweet gives a table of the results of a comparison of the amounts of gauze and cotton used during different periods in the four acute surgical wards of the hospital. Each ward is in charge of surgeons of equal skill, and all trained in the same hospital; the nurses are also all graduates of the same hospital training school; in other words, the comparison is not between workers trained in different schools of surgical technique.

TABLE I.—*Gauze and Absorbent Cotton Used July 5, 1917.*

Ward.	Gauze (6-yard rolls).	Cotton (1-yard rolls).	Treatment.	No. of Patients.
1	12	2.5	Eusol	23
2	10	4	Eusol	22
3	3.5	2.5	Dichloramin-T	23
4	5	2.5	Eusol	25

Taking a longer period, the amount of gauze and cotton used in seven days by three of the acute surgical wards is given in Table II. Ward 2 changed during this period from the use of eusol to the use of dichloramin-T; the figures from this ward are therefore not available. The number of patients was the same in the three wards, and the proportion of relatively slight and extensive wounds in each ward was the same.

TABLE II.—*Gauze and Absorbent Cotton Used from July 4 to July 10, 1917, inclusive.*

Ward.	Gauze (6-yard rolls).	Cotton (1-yard rolls).	Treatment.
1	72	38.5	Eusol.
3	33	7	Dichloramin-T.
4	45	18	Eusol.

This saving of material is of importance in several ways. Not only does it effect a saving of labor from the cotton field to the hospital, not only a saving of transport, but an important saving in the hospital itself; the time taken by the nurses in the preparation and sterilization of material can be utilized for the care of the patients, and to this can be added the saving in time, labor and material by doing away entirely with the need for the Carrel tubes. The need for so little solution in wound dressing, and the fact that the dressing need only be sufficient to care for the wound discharge means that the bed linen is not wet, with a consequent saving in the moving of the wounded, and an increase in their comfort and well being.

The dichloramin-T solution, like all the other chlorin compounds, is a very active lymphagogue in fresh wounds, and the amount of wound excretion may be considerable. The lymphagogic effect may be directly watched in suitable wounds. As granulation tissue develops, the lymph discharge greatly decreases until the wound becomes comparatively dry. The dichloramin-T also possesses to a marked degree the characteristic power of the chlorin solutions in aiding the digestion and removal of necrotic sloughing tissues. The new solution seems more effective in cleaning up sloughing tissue than the older chlorin compounds. While the majority of our cases come from the casualty clearing station in excellent clean condition, a sufficient number have reached us with necrotic tissue in the wound amply to satisfy us of the rapidity with which the dead tissue is freed under the dichloramin-T. The tendency to secondary hemorrhage is certaintly not increased. We have had only one secondary hemorrhage in the series, which includes a number of deep buttock wounds, and cases of exposed great arteries of the arm and leg.

The solution is not irritating to the skin or mucous membrane, except possibly in the rare individual who possesses an idiosyncrasy to the eucalyptus oil. The constituents of the solution are stable although the final combination is not indefinitely stable nor can it be exposed to strong light. It is easily prepared from the constituents. The dichloramin-T was put up in packages of 10 grams each; the content of one package is dissolved in 75 c.cm. of chlorinated eucalyptol and diluted with equal parts of chlorinated paraffin oil as needed, making, therefore, approximately a 6.5 per cent. solution of dichloramin-T.

The first application of the solution to a fresh wound produces a smarting or burning sensation, which passes away in a very few minutes. After the second or third application this smarting sensation on applying the solution seems to have disappeared.—(*Brit. M. J.*, Aug. 25, 1917.)

Primary Removal of Projectiles.

Stabsarzt Professor Rehn has discussed (Bruns' *Kreigschir.*, Heft, 1917, xxxvi, p. 220) gunshot wounds from the point of view of the primary removal of lodged projectiles. While primary removal should never be undertaken in uncomplicated wounds of the thorax, in wounds of the extremities, when produced by fragments of large or medium size, it constituted the standard treatment. On the other hand, in presence of a widely open pneumothorax with laceration of the lung primary removal was desirable, while in cases of multiple grenade wounds of the extremities and of the superficial soft parts of the body generally no systematic removal should be undertaken, as the small fragments either become encapsulated or readily discharged if suppuration occurred around them. Operation on the abdominal cavity was never performed solely with a view to removing the projectile. The time for operating must largely be determined by external circumstances, but removal of a lodged projectile should be carried out in the primary stage whenever possible, since operative measures were frequently useless after the lapse of a few days. Operation in the intermediate stage, which commenced about thirty-six hours after wounding, was especially to be avoided. During this period there occurred a renewed bacterial invasion and greatly increased vulnerability of the tissues, most distinctly marked in wounds of the head, but no less dangerous in those of the extremities and body cavities.

Brain: Expectant treatment was as a rule adopted, even where the foreign body had been precisely localized. In specially favorable conditions, when the fragment was of such size and in such position as to be easily reached, and was of a kind suitable for the use of the magnet, extraction was permissible in the primary stage. In the intermediate stage, all intervention not imperatively called for was avoided, any additional injury inflicted in this stage being liable to be followed by rapid spread of the infection to the vital centres or ventricles, or, in more superficial injuries, by extensive prolapse. The rule, therefore, was that removal of the projectile in the primary stage was permissible in certain conditions, but inadmissible in the intermediate stage.

Abdomen: In penetrating wounds of the peritoneum, with wound of the viscera, operation was directed to the injuries inflicted rather than the removal of the projectile. The preliminary localization of the latter was therefore omitted, since it increased the depression of the patient. Moreover, it was unwise to place too much reliance on indications derived from the *x*-rays, for wounds which appeared to be purely superficial often proved to be accompanied with contusion of the viscera, perforation of the peritoneum, and subcutaneous prolapse through small peritoneal wounds, Penetrating wounds of the abdomen were preferably treated at the main dressing station, reinforced with a small operating section from the Feldlazarett. The erroneous view was still held by some surgeons that it mattered little whether an abdominal case was transported five or fifteen miles, the delay in operating being but trifling. The time of operating was, however, of small importance compared with the depression in the patient's condition resulting from prolongation of the transport. Operation was not undertaken during the period of shock, nor immediately on the improvement in the patient's condition which followed the use of stimulants and intravenous injection; unless this improvement persisted for several hours, time, which could be devoted to other patients, was not wasted on the case. Except where the peritoneum was extensively contaminated with feces, irrigation was restricted as much as possible, especially when evidences of localization of the inflammatory process existed; unnecessary displacement of the viscera was avoided. Clinical indications often served as a guide to the internal injuries, but in the absence of these no prolonged search for the projectile was made, for as a rule it was readily found in all cases where its removal was possible. By a strict adherence to these details Rehn succeeded in reducing the mortality in abdominal wounds with lodged projectiles to 50 per cent.

Extraperitoneal wound of the large intestine was suitable for primary operation, but this was often impracticable owing to difficulties in diagnosis, except when a primary fecal fistula was present. Primary removal was also performed in extraperitoneal wounds involving the bones of the pelvis. Delay in operating in these cases beyond the first twenty-four to thirty-six hours exposed the patient to general infection from the loose cellular tissue of the pelvis.

Thorax: In the primary stage expectant treatment was, as a rule adopted, and in uncomplicated cases operation was restricted to aspiration, even in presence of severe infected hematoma, until adhesions had securely fixed the lung and isolated the effusion and pulmonary wound—that is, until the nineteenth day. This rule was necessarily discarded in cases complicated with grave hemorrhage (lungs, heart, great vessels) or open pneumothorax. The customary treatment of open pneumothorax was to open up the pleural cavity widely. But this course was followed by numerous failures attributable mainly to three causes: (1) Loosening of the sutures between lung and chest wall, with consequent incurable secondary pneumothorax; (2) death from the third to the fifth day, with signs of commencing general infection; or failure to rally after the operation, due to traction on the hilum of the lung caused by the lung fixation; (3) the shock of the operation superadded to that of the injury and subsequent transport.

Rehn based his treatment on a consideration of these facts. Wide opening up of the pleural cavity was adopted only where severe hemorrhage was present or the chest wall had been extensively ripped up by the injury, and in such cases alone was an attempt made at primary removal of the projectile. The danger of dragging on the hilum of the lung was avoided by the use of percutaneous sutures for lung fixation; this had the additional advantage of bringing large areas of the pleural surfaces evenly into contact. The sutures were placed in the third or fourth intercostal space anteriorly, laterally in the fourth or fifth, and posteriorly in the fifth, and were left in for eight days. Open pneumothorax without great loss of substance in the chest wall received purely expectant treatment, the patient being placed in a suitable position and excision of the wound being dispensed with. Percutaneous fixation of the lung was performed in such cases when there was severe infection of the wound, in view of the possibility of secondary pneumothorax arising. Cases of open pneumothorax somewhat severer than these were treated by excision and primary suture of the wound with lung fixation as above described. For expanding the lung in these cases careful aspiration of the pleural contents was preferable to the use of pressure apparatus. Rehn reckoned the intermediate stage in wounds of the thorax as extending from the second to the nineteenth day. In this stage treatment was as far as possible expectant. Apart from severe secondary hemorrhage the only condition that could give rise to doubt as to the line of treatment was acute empyema. This condition, complicating an even temporary pneumothorax, was much graver than the ordinary infected hemothorax, and if neglected might be succeeded by a rapidly fatal general infection.

In spite, therefore, of the danger from secondary open pneumothorax and post-operative general infection which operation in the intermediate stage involved, rib resection was performed if the case appeared to be urgent. The resection was carried out after the fourth day, when the empyema might be considered to have become localized. In the secondary stage conditions were favorable for the removal of a lodged projectile. Rehn deferred the description of the method to be employed, merely stating that he was in favor of early removal, at the same time giving a warning that it could not be successfully undertaken in the absence of clear indications, and an appreciation of the difficulties to be encountered.—(*Brit. M. J.*, No. 2958, 1917.)

The Department of Oral Surgery of the Harvard Surgical Unit.

Major V. H. Kasanjian makes this report. Cases are admitted to the department usually from two to three days after injury. They are suffering from mental shock, toxic absorption from the wounds, and from lack of nourishment owing to the inflammation of the soft tissues and the derangement of the organs of mastication.

The mouth is irrigated at frequent intervals during the day and night, in most cases every two hours, and in addition the mucous surfaces are swabbed with cotton pledgets saturated in tincture of iodin or hydrogen peroxide, to remove mechanically mucous deposits and adherent food particles.

The majority of operations are performed under a local anesthetic. This procedure makes it possible to remove foreign bodies, fragments of teeth or roots, and detached segments of bone. The suppuration or necrosis during the early stages of treatment is thus materially reduced.

They believe that early immobilization of maxillary fractures means the quickest and most satisfactory recovery. While technical difficulties may stand in the way, since nearly every splint must be made to suit each individual case, they have devoted considerable attention to the classification of the type of splints, and the simplification of their preparation.

For cases of ordinary severity, the usual splints (with or without modifications) familiar to the oral surgeon are used. In many cases of extensive destruction of hard and soft tissues it was found that intraoral splints were inadequate, and an external support, consisting of a series of vulcanite plates fitted over the forehead, with a headgear of straps, was developed. With this appliance as a base, the tissues of the mouth, nose, eyes, and neck are under control, either during the process of scar contraction or after plastic operations.

In the many cases of extensive loss of the mandible accompanied by laceration of the lower part of the face and neck, a sectional or folding artificial jaw has been successfully used; its acts as a framework for plastic operations, is easily removed, and at the same time maintains the contour of the lower part of the face.

In restoring the upper jaw, a satisfactory means of retention and also of resistance to the force of mastication has been designed, and in cases in which the loss of the mandible has been sufficiently extensive to destroy the function of the temporo-mandibular joint, a mechanical condyle has been substituted.

The special septic complications, apart from the usual condition of local sepsis in the wound, which have been observed, are septicaemia, cellulitis, and bronchopneumonia. No cases of pyaemia have occurred.

Septicaemia.—There have been two cases of septicaemia, both ending fatally. In each the wounds of entry and exit were small. In one there was a scarlatiniform rash and the infection was thought to be streptococcal, but no blood cultures were made. In the other, growths of a bacillus were obtained from samples of blood taken on two successive days. The bacillus was not identified, as it died off in all the subcultures.

Cellulitis.—A form of cellulitis spread from the wound over the face and scalp has been observed in several instances. It was accompanied by pyrexia, but in no case did the patient seem very ill or suffer from any serious consequences. The affected area of skin has been light pink in color, slightly tender, with a definite induration at the spreading margin. These cases have been regarded as mild erysipelas, and have been treated as such. In some instances the condition has recurred in the same patient.

Bronchopneumonia.—This has been one of the most fatal complications. Preliminary septic bronchitis has occurred in some cases; in others the onset of pneumonia has been sudden. Empyema and multiple abscesses in the lung have been common, and the mortality has been high. The pulmonary infection seems to be attributable, as a rule, to the inhalation of septic material from the mouth, and a high percentage of the cases has followed general anaesthesia. Many patients were suffering from bronchopneumonia at the time of their admission, and it was usually found that they had already been operated upon elsewhere under general anaesthesia.

The practice now is to employ local anesthesia whenever this is possible for operation upon patients with wounds which communicate with the mouth. If general anesthesia is necessary, special precautions are taken to prevent the entry of septic material into the air passages.

So far as concerns the soft tissues, these are considered under the following headings:

1. *Primary Suture.*—There does not appear to be much scope for primary suture of gunshot wounds complicated by fracture of the jaw, for reasons which are manifest. However, so long as general anesthesia is not employed, some advantage may follow accurate primary suture of those portions of a wound which involve the lip margins, the eyelids, the alae of the nose, portions of the external ears, or the outlying tributaries of a radiating wound, provided such suturing is limited, and no attempt is made to close the entire wound.

2. *Secondary Suture.*—Early secondary suturing has been increasingly employed of late. The interval that has been allowed to elapse between the infliction of the wound and its complete or partial closure has varied with the condition of local sepsis, but has most often been between the fifth and twelfth days. B.I.P. has been used as an adjuvant in these operations. The use of early secondary suturing has done much to lessen the amount of deformity from scarring.

3. *Flap Operations.*—Although primary or early secondary suturing may be practised with success in some cases, yet extensive operations required for reconstruction of the face to cover deficiencies which have been brought about by actual destruction of tissue, or by scarring and laceration, are invariably postponed until all suppuration has disappeared. Primary or early secondary suturing may have served to bring the edges of a lacerated wound into apposition or suturing may have been done at a later date to extend mucous surfaces or to lessen the deformity as a preparatory measure for an extensive plastic operation. In other words, in the first instance the suturing reduces the size of a wound in which there is no loss of substance, and in the second instance it lessens the area to be covered by flaps. In all cases in which there is an appreciable loss of substance and a plastic operation is contemplated, an appliance to reproduce the bony tissue is always made to serve as a framework, to give a natural contour to the soft tissues of the face or neck, and to prevent undue scar contraction.

Even for extensive plastic operations local anesthesia is almost invariably used, because the majority of patients prefer it to a general anesthetic, while from the operator's point of view it is better because he can take his own time to obtain juxtaposition of the flaps, the loss of blood is much less, the patient is quiet and under perfect control, and the dangers of a prolonged operation are reduced to a minimum.

Among 400 cases of gunshot wound of the face with fracture of the upper or lower jaw treated in this department there have been 34 cases of secondary hemorrhage (8.5 per cent.), and of these 7 were fatal.

Injury of one or both lingual arteries in the floor of the mouth has been the chief cause of serious bleeding. In the majority of cases it has not been possible to secure the bleeding point, and proximal ligature has been employed. This, however, has not always been satisfactory, as it is often impossible to identify with certainty the vessel which is bleeding. Efforts to overcome this uncertainty by ligating the external carotid artery were not encouraging. Owing to the dropping of the fractured jaw and other anatomical and pathological derangements, the external carotid is not easy to find and ligate in these cases, the operation is somewhat prolonged and has a high mortality; moreover, concomitant injury of both linguals is not uncommon, in which event ligation of one external carotid is not sufficient. Recently we have had better results by direct ligation of one or both lingual arteries whenever the anatomy of the wound was indicative of injury of these vessels.

Of 436 recorded cases of injuries to the face and jaws treated in the department between July, 1915, and January, 1917, 19 patients died from the following causes:

Hemorrhage	7
Bronchopneumonia	5
Cerebral complications	4
Septicemia	2
Collapse	1

It is hard to make an accurate analysis of the percentage of deaths among patients suffering from gunshot wound of the face and jaw, because wounds of other parts of the body may exist which are of more serious consequence than those of the jaw. Of the four cases which died from cerebral complications, three were suffering from fracture of the base of the skull and one from spinal injury in addition to the jaw wounds.

Most of the patients who succumbed to bronchopneumonia had contracted this complication previous to admission to the department.—(*Brit. Med. J.*, July 7, 1917.)

Correspondence

Noise and War Bread.

131 FIELD AMBULANCE, B. E. F., FRANCE.

To the Editor of the MEDICAL TIMES:

We have been moving about so often and so hurriedly that it is difficult to know exactly where we are going to be from time to time. However, I now seem to be established and hope to be at this station for awhile.

The principal thing is that it is too close to the firing line for one's peace of mind. I do not know of any two sounds more disagreeable than those of a shell and a bomb, and I had not been here many hours before I learned to recognize both sounds.

We really know less of what is going on than you, and we have very little time to read papers anyway. New Lebanon, N. Y., my home, seems very far from here, and I would give a great deal to spend a few days in quiet there after these few months of hell—that is the only way I can describe this noisy place.

We have had a good many wounded prisoners during the last few weeks, most of them either young boys from 17 to 19 or men between 45 and 60. They get the same treatment that our own boys receive—a warm drink and a bite to eat before going down the line—and you should see how these poor chaps go at the sandwiches. You would not wonder at it if you had seen this war bread. It looks like a wooden paving block, weighs much more and is almost as hard to cut. I have not yet had the nerve to taste it.

The steel helmets we wear are surprisingly comfortable.

(*Continued on p. 22*)

"ROCHE"

To the Medical Profession: New York, 1917.

For three years of the world's war we kept the prices of "Roche" specialties at ante bellum level. While some revisions have now become unavoidable, the most frequently used dosage forms of

Digalen and **Pantopon**

(Pantopium Hydrochloricum), also our ampuls, remain at the old prices; more important still, these and all our other preparations, **Thiocol**, **Thigenol**, **Sedobrol**, etc. (with the sole exception of **Larosan**) are quite freely available.

The Hoffmann-La Roche Chemical Works.

INFANT FEEDING

In extreme emaciation, which is a characteristic symptom of conditions commonly known as

Malnutrition-Marasmus-Atrophy

it is difficult to give fat in sufficient amounts to satisfy the nutritive needs; therefore, it is necessary to meet this emergency by substituting some other energy-giving food element. Carbohydrates in the form of maltose and dextrins in the proportion that is found in

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are especially adapted to the requirements, for such carbohydrates are readily assimilated and at once furnish heat and energy so greatly needed by these poorly nourished infants.

The method of preparing the diet and suggestions for meeting individual conditions sent to physicians upon request.

MELLIN'S FOOD COMPANY, BOSTON, MASS.

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ORGANIDIN—WAMPOLE

Dr. . . . . , a prominent western physician, reports a case of blood-pressure of 280 which Organidin in 10 min. doses reduced to 210 in one week. Patient is still taking the preparation and is steadily improving. No disagreeable symptoms from its use have been noted.

Trade-size package mailed to any address postpaid on receipt of $1.00
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MANUFACTURING PHARMACISTS, PHILADELPHIA, U. S. A.

(*Continued from p. 334*)

They are very necessary for wear outside and in the house they serve every need of the washbasin.

One difficulty we find is lack of mail from the United States. It only reaches us once in a while, so it is hard to keep tabs on things at home. N. P. BROOKS, M. D.

"Prayers for Profit."

To the Editor of the MEDICAL TIMES:

Contrary to the statement, "Prayer for Profit," in your September issue, it would be difficult for anybody to name a religious organization that numbers in its membership more men and women who are or have been prominent in the learned professions.

For example, there are to be found on the Christian Science Board of Lectureship men once foremost in the law, medicine, theology, literature, art, etc. Furthermore, Christian Scientists will everywhere be found playing an important and constructive part in the affairs of the world.

The statement that Jesus did not exact payment from those whom he treated and healed may be true, if by that is meant that he did not compel them to pay. But that he did not expect them to pay cannot be proved. Certain it is that he received compensation of some kind from somewhere.

Furthermore, the Scripture (Luke 10:7) indicates that Jesus expected his students to receive adequate compensation in the medium of exchange customary in those days. Surely, then, Christianity is not "commercialized" merely because its practitioners of today accept compensation in terms of dollars and cents instead of in terms common to an earlier period.

No fairminded doctor or other tolerant person would assent to a scheme to penalize those who through the study of "Science and Health," by Mrs. Eddy, are again making Christianity practical by restoring to it the lost element of healing, especially when Christian Science uniformly heals where other methods fail.

Let critics of a practical Christianity bear in mind that the only practitioner who ever treated the sick without a recorded failure was Jesus of Nazareth, and that he did this without resorting to either drugs or surgery.

ROBERT S. ROSS.

Rapid Growth of the Birth Registration Area.

Congratulations to Maryland, Virginia and Kentucky, the latest states to be admitted to the Registration Area for Births by the Director of the Census.

The Registration Area for Births was established in 1915 and was then composed of ten states and the District of Columbia, representing 10 per cent. of the territorial extent of the United States, but containing 31 per cent. of the country's population. For this area the Bureau of the Census has recently issued its first annual report, entitled, "Birth Statistics." As the area grows the annual reports will deal with the births in a constantly increasing portion of the country and will, therefore, become of constantly increasing interest and value.

The outlook for a very rapid growth of this Registration Area for Births is so good that a word of cheer to the states outside should be given. The need of complete birth registration is recognized now as never before. The age of the soldier must be known, and so a new argument for birth registration comes to the United States. Since war was declared tests of the completeness of birth registration have been made by special agents of the Census Bureau in Virginia and Kentucky, and both these states secured a rating of over 90 per cent., which represents the degree of completeness required for admission to the area.

Similar tests are now being made in Indiana and New Jersey, and before the year is over will be conducted in North Carolina, Ohio, Utah, and Wisconsin. Several other states are nearly ready to seek admission, and it is by no means a wild prediction that the Birth Registration Area within the next two years will be more than trebled in size and will contain over two-thirds of the population of the United States.

One physician recently became so thoroughly aroused to the desirability of recording births that he reported to the local registrar 450 births which had occurred in his practice since 1900.

Parents and physicians everywhere are awakening to the importance of this matter and the fashion now is to register baby's birth.

Do not claim to live by the golden rule and then sneeze in somebody's face.

80% of All Cases of Indigestion

are due to the inability to digest and assimilate starchy foods. Since considerably over one-half of the daily diet of the average person is made up of the carbo-hydrates, the urgent necessity for appropriate treatment can be seen at once. Neglect to correct **starch indigestion** means a progressive increase of the difficulty and a constant nutritional decline that sooner or later lower vital resistance and render the body susceptible to all manner of disease. To correct starch indigestion and overcome its consequent ill effects, there is no remedy so promptly and uniformly effective as

Trommer Diastasic Malt Extract

Honestly made from the best barley malt, for nearly half a century this high grade product has been widely and successfully employed by careful, discriminating physicians who have recognized its remarkable tonic and reconstructive properties. Exceptionally rich in natural diastase, maltose and other nutrient extractives, it has been used with conspicuous benefits in **malnutrition, diabetes, incipient tuberculosis, as a substitute for cod liver oil, in infant feeding and in all forms of bodily decline whenever carbohydrate metabolism is defective or impaired.**

In starch indigestion Trommer's Extract of Malt is practically a specific, and through its influence on the digestive functions it can be relied upon to produce substantial and lasting results. To countless physicians, therefore, Trommer's Extract of Malt is not only the ideal corrective of starch indigestion, but also the most dependable and satisfactory reconstructive at their command.

THE TROMMER CO. **Fremont, Ohio**

LISTERINE

A trustworthy, unirritating solution composed of volatile and non-volatile antiseptics extensively and satisfactorily employed in dilution up to 25% as a wet dressing for surgica and accidental wounds.

LISTERINE

Suitably diluted, applied by injection, douche or spray, often serves a useful purpose in catarrhs and conditions involving hyper-secretion from mucous surfaces. It is an efficient deodorizer.

LISTERINE

On account of its boric and benzoic acid constituents, forms a suitable lotion in dermatitis following vaccination. In various cutaneous disorders, its use allays excessive itching or irritation, and promotes cleanliness while exercising its antiseptic effect.

Descriptive literature on request

LAMBERT PHARMACAL COMPANY

Twenty-first and Locust Streets **St. Louis, Mo., U. S. A.**

A Rational Treatment of Pyorrhea Alveolaris.

M. P. HART, D. D. S., New York.

Since Riggs of Hartford, advocated scaling and polishing the teeth forty years ago, this procedure has been followed with scant modification for the cure of Pyorrhea. Innumerable drugs have been advocated in the past few years with indifferent results.

A great majority of the dental profession, including pyorrhea specialists, have gone back forty years and are again scaling and polishing the teeth and endeavoring to remove the so-called serumal deposits by instrumentation in the forlorn hope of effecting a cure.

To M. H. Cazier, M. D., of New York, I wish to give all credit and believe the dental profession and suffering humanity owe him a lasting debt of gratitude.

Pyorrhea alveolaris is the result of lowered vitality and low resisting power caused by faulty circulation, because the parts are not properly supplied with arterial blood and do not receive the proper nourishment to perform their normal function. Tartar malocclusion, faulty dentistry, etc. are among the irritating causes and are very important factors, and must receive the proper attention. The irritant must be removed, but I do not believe a single case of pyorrhea has ever been permanently cured by only removing the local irritation.

The treatment which I have successfully followed in the past two years, consists of a rubber cup (devised by Dr. Cazier) fitted to the mouth, attached to a suction pump producing a partial vacuum (Biers' hyperemia). The suction thoroughly aspirates the pockets, draining off all waste material. There is a valve attached to a bottle for the purpose of releasing and closing the air. By the operation of this device, the rubber cup flaps and the gums receive a gentle massage. After the daily use of this vacuum appliance, when the vital conditions are in a measure restored, inject into the lesions a 20 per cent. alcoholic solution of sulphuric acid. The acid irritates the live tissues, causing them to swell. The dead tissue shrinks, separating from the living, and the exfoliation of the so-called serumal deposits follows. Sulphuric acid is a good germicide and invites osteoblasts and other cell proliferation.

We repeat this treatment about once a week, having the patient use the vacuum appliance daily. The result is complete recovery. At the beginning of the treatment I always prescribe Entol and recommend its daily use as an antiseptic and prophylactic mouth wash. The patients like its taste and it makes the mouth feel clean and refreshed.

Medical men have conceded that a large percentage of diseases that men are heir to, are primarily caused by mouth infection. So I submit this paper for their consideration, and ask them to further investigate this treatment. I believe they will agree with me that this is the only rational way of treating Pyorrhea Alveolaris.

Internal Secretions.

One of the best written booklets on this subject we have seen is entitled "The Role of the Internal Secretions in Promoting Digestion," prepared by Reed & Carnrick, Jersey City. While the general intent is to demonstrate the physiological applicability of Peptenzyme in the various disturbances of the gastro-intestinal tract, the author has given a careful and accurately prepared resume of the subject which is worthy of study. This old firm has done much for physiological therapy and is always in accord with the latest scientific thought.

It is of interest to note that the president of the firm, Dr. August Sartorius, who is a first lieutenant in the Medical Reserve Corps, U. S. Army, is a student officer at Fort Benjamin Harrison.

Disease in Milk: The Remedy, Pasteurization.

We are glad to direct the attention of the profession to the work by Lina Gutherz Straus by the title above and published by E. P. Dutton & Co., of New York. It is an important contribution by a distinguished writer.

There is a Milk Problem because milk is the only animal food taken in its raw state (page 28). There are six plagues—typhoid fever, diphtheria, scarlet fever, septic sore throat, tuberculosis and the summer complaints of children—that may be transmitted by raw milk (page 345).

Pasteurization destroys all the germs of disease that may be in the milk, but does not impair the taste, digestibility or nutritive qualities of the milk (page 31).

Pasteurization consists in heating milk to a temperature of 145 degrees Fahrenheit and holding it at that temperature for half an hour.

In the Nathan Straus Laboratory the best certified milk is used. It is filtered, clarified and modified in five different mixtures according to formulas prescribed by eminent physicians. These formulas are adapted to babies of various ages and conditions. The milk is then pasteurized in the bottle and quickly cooled to below 50 degrees (pages 33-39).

The pasteurized milk is sold in New York at eight stations in winter, at eighteen in summer, at a nominal price. It is the only "ready-to-drink" milk for babies to be had in New York City (page 41). In the twenty-five years of this work 42,873,181 bottles and 24,009,498 glass of pasteurized milk have been dispensed at the Straus stations (page 77).

Coincident with the development of this work the death rate among children under five years of age has dropped from 96.2 per thousand per annum in 1892 to 34 per thousand in 1916, the mortality statistics of the City Health Department indicating the saving of 241,930 lives in these 25 years (pages 90-91).

The efficacy of pasteurization was mathematically demonstrated at Randall's Island, where the death rate among the city's waifs was cut from an average of 41.81 per cent. to 21.75 per cent. without any other change in diet or regimen than the substitution of pasteurized milk for raw milk (pages 51 and 204). Also at Sandhausen, Germany, where all the children under two years were supplied with pasteurized milk and the death rate was cut from 46 per cent. to 20 per cent. (page 96). Also at Karlsruhe, Germany, where one-fifth of the babies were supplied with pasteurized milk and the death rate among them was only 6.3 per cent., while in the entire city the death rate was 17 per cent. (page 97). Also in Washington, D. C., where the death rate among Straus babies was only 6.2 per cent. (pp. 103, 209).

It was a long fight against prejudice that led to the adoption of pasteurization by the City of New York (pages 51-59) and by the State of New York (page 60). Beginning with Chicago, in 1909, and New York in 1913, the cities have fallen in line, until in 1917 pasteurization is either required or encouraged in 46 of 52 lragest cities of America (pages 70-71).

The first Infant Milk Depot in America was founded by Mr. Straus in 1893. Now there are 297 such depots in the 36 leading cities of the country (pages 75-79).

As a considerable factor in the suppression of tuberculosis, pasteurization has demanded attention and acceptance. Dr. E. C. Schroeder, of the U. S. Department of Agriculture, proved that "one of the chief, if not the most important source of infection is the tuberculous dairy cow" (page 219), and that "nothing as efficient or economical as pasteurization to make milk safe has been discovered" (page 21).

Dr. M. P. Ravenel, who proved the communication of bovine tuberculosis to children, holds that "pasteurization has been the means of saving the lives of many infants and children" (page 20).

Pasteurization has been endorsed by the American Medical Association, the National Association for the study and Prevention of Tuberculosis, the American Public Health Association, the U. S. Public Health Service, and the National Commission on Milk Standards, which is made up of seventeen recognized experts.

In order that no baby may be deprived of properly pasteurized milk, Mr. Straus in 1909 perfected a "foolproof" Home Pasteurizer, which any tinsmith can make and any mother can operate. The plans and directions for manufacturing and for use are supplied free to anyone who applies (pages 85-88).

Professor Abraham Jacobi, dean of American medical men, in the introduction to Mrs. Straus' book, says:

"It is more than two dozen years since Nathan Straus began and carried out his life-saving practice. His methods are simple and direct; his results satisfactory to the infant. These are, after all, the best critics of what is being done for them. Long may they continue to live—Nathan Straus and his many babies in many lands" (page 19).

All that has been said for pasteurization applies with equal force to cream, butter, ice cream and cheese. All cream, including that used for ice cream and butter, should be properly pasteurized to be safe. There is nothing in the process of making butter, cheese or ice cream to impair the vitality of disease germs. Cold does not kill them; only by heat (pasteurization) can they be destroyed (pages 109-110).

BACK THE BOYS IN THE TRENCHES

BUY A LIBERTY LOAN BOND

Inquire at any Bank or Post Office

Johnson & Johnson Announce a Perfect Process of Preparing the Carrel-Dakin Solution.

Through the perfection of the process of preparing the Carrel-Dakin Solution for the antiseptic irrigation of deep wounds, the Carrel method of wound sterilization is placed at the disposal of every surgeon.

The success of the Carrel method in France and this country has deeply interested the medical profession, but until now the Carrel-Dakin Solution could only be supplied to hospitals.

The methods heretofore used for preparing the Carrel-Dakin Solution have been based upon the use of bleaching powder, and therefore suffered from the inherent drawbacks that bleaching powder is heir to, particularly that of stability.

This necessitated an analytical test each and every time a new batch of the solution was prepared. In addition there has been troublesome settling, decantation and filtration to eliminate the lime sludge.

All this has hindered the general adoption of the Carrel method.

We have acquired from the Electro Bleaching Gas Company their method of encasing liquid chlorin in glass ampoules, and are therfore able to announce a perfect process of preparing the solution.

We supply the elements which make up the solution as follows:

Liquid chlorin in glass ampoules, each ampoule containing a definite weighed quantity of chlorin of the exact amount required to produce one liter of solution of standard strength, between .45% and .50% of sodium hypochlorite, and an accompanying tube of sodium salts exactly proportionate to the amount of liquid chlorin.

All that is necessary to do is to dissolve the contents of these tubes in water and there is produced a perfectly clear hypochlorite solution ready for use. No filtration is necessary: no analysis is necessary: there is no troublesome lime sludge to be disposed of.

The preparation is offered with the assurance that the surgeon may absolutely rely upon its being the same each and every time. The liquid chlorin is not affected by light, by ordinary temperature conditions, and is absolutely stable, usable under any and all conditions of climate, etc.

We believe this to be the greatest and final step necessary to place the Carrel - Dakin method of wound sterilization in the hands of hospitals and the medical profession.

Chlorin Ampoules, Johnson & Johnson, may be obtained through physicians' supply houses and the Drug Trade.

Circular descriptive of the methods of use accompanies the ampoules. A copy will be sent to to any physician upon request.

Johnson & Johnson

New Brunswick, N. J., U. S. A.

SURGODINE IS

all iodine; there are no side-salts to hamper the the ideal iodine antiseptic action.

SURGODINE DOES

quickly produce the full iodine effects always desired and demanded by surgeons.

SURGODINE DOES NOT

cause any irritation when freely applied—properly diluted—to an open wound.

In 4-oz. and pints at leading pharmacies.

SHARP & DOHME

Since 1860

Purveyers to Particular Prescribers

A Substitute for Meat.

"Meatless Days" and the oft repeated warnings that economy in food is necessary to win the war, has called attention to a meat substitute invented some years ago by Dr. J. H. Kellogg, superintendent of the Battle Creek Sanitarium. The suggestion came from the Department of Agriculture at Washington, in protose, a purely vegetable compound, Dr. Kellogg combined the qualifications which he regarded as essential in a food which could satisfactorily replace meat. It contains none of the parasited or putrefactive germs harbored by meat; it is made to resemble potted meat in its physical aspects; it is palatable and chemically, is a reproduction of meat; furthermore, in large quantities it can be placed on the market at a (lower price than the product which it is) meant to displace. Each year sees a lessening of the herds, droves and flocks of the country, and the war has greatly accelerated the movement. The housewife will therefore welcome such an article as protose, which will lesson or end her dependence on the butcher.

Clinics at the Long Island College Hospital.

The medical profession is cordially invited to attend the obstetrical diagnostic clinics at the Long Island College Hospital which will continue until June 1, 1918.

Dr. John Osborn Polak and Frederick C. Holden will hold a clinical conference on obstetric and gynecological cases in the amphitheatre of the hospital, every Saturday morning, at 11 o'clock, immediately following the regular operative clinic, 9 to 11.

The following subjects will be discussed: Nov. 3, The management of septic incomplete abortions—illustrative cases. Nov. 10—Pathology, diagnosis and treatment of ectopic pregnancy. When to operate. Nov. 17—Diagnosis and pathology of hydatid cysts and chorioepithelioma. No. 24—Demonstration of normal and abnormal placentae, membranes, etc., showing the significance of placental study in the conduct of subsequent deliveries. Dec. 8—Demonstration of the technique of normal labor in private practice. Simple intensive asepsis. Dec. 15—Demonstration of the mechanism and management of occipito-posterior positions of the vertex. Dec. 22—Indications and use with demonstration, of the several methods of dilating the cervix.

Beginning January 5, 1918: Demonstration of the anatomy and of the proper intermediate repair of puerperal injuries, inment by operation—by Radium, by *X*-ray. Preoperative preparation of the gynecological patient. How each case should be worked up to give the woman her greatest margin of safety. Retroversion—its pathology—indications for treatment—the sphere of the pessary—of operation—consideration of the end results. Anesthesia in labor.

A Timely and Generous Gift.

The kindness of the American people shown to the brave young men who are fighting in defence of the country's honor cluding the making and the repair of perineotomy wounds. Diagnosis of contracted pelves and a demonstration of the mechanism of labor through flat, generally contracted and funnel pelves. Demonstration of the technique and detail of low and median forceps deliveries. The pathology of fibromyoma of the uterus. The diagnosis and indications for treatwas charmingly exemplified a few weeks ago, when Mrs. R. Harding, of St. Louis, presented to the Medical Corps of the 12th New York Infantry, just before the regiment left for Camp Wadsworth, Spartanburg, S. C., with a handsome seven-passenger automobile in memory of her late husband.

The needs of the 12th Regiment for a car came to Mrs. Harding's attention through First Lieutenant Frederic R. Mason, M. C., and she hastened to send a gift which meant so much for the comfort of the officers of this famous organization of fighting men.

The medical officers delegated Lieut. Mason to accept the generous gift in their name and this was done in a most gracious and gallant manner. The automobile is now a familiar sight in and around Spartanburg and it is materially lightening the burdens of the medical officers of the 12th.

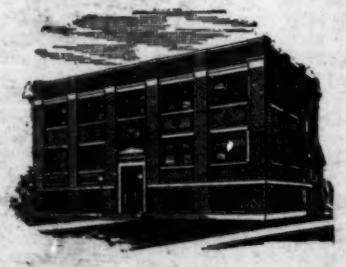
PROPERTIES consist of 30 buildings—accommodations for 1,200 patients—20 acres of beautiful shady lawns—model dairy—extensive farm and greenhouse systems—pure artesian water supply—large staff of specializing physicians, nurses, dietitians, physical directors and general assistants—wholesome, nutritious bill of fare—thoroughgoing diagnostic methods—complete, modern therapeutic equipment—splendid facilities for outdoor recreation.

THE BATTLE CREEK SANITARIUM

Box 335 Battle Creek, Michigan

USE VACCINES
IN ACUTE INFECTIONS

The early administration of Sherman's Bacterial Vaccines will reduce the average course of acute infections like Pneumonia, Bronchopneumonia, Sepsis, Erysipelas, Mastoiditis, Rheumatic Fever, Colds, Bronchitis, etc., to less than one-third the usual course of such infectious diseases, with a proportionate reduction of the mortality rate.



Sherman's Bacterial Vaccines are prepared in our specially constructed Laboratories, devoted exclusively to the manufacture of these preparations and are marketed in standardized suspensions.

Write for literature.

MANUFACTURER OF BACTERIAL VACCINES

G. H. SHERMAN, M.D.
Detroit, Mich. U.S.A.

The end products of protein digestion are now known to be amino acids—when the essential nitrogen is ready for blood absorption.

Liquid Peptonoids

contains

Amino Acids

To the extent of 24% of the total nitrogen.

Available for rectal as well as oral feeding.

Samples and literature on application.

The Arlington Chemical Co.
Yonkers, N.Y.

Bleeding Hemorrhoids.

There are few ailments more alarming and distressing to a patient than bleeding piles. Unquestionably, unless promptly checked, such a condition is very apt to lead to serious consequences. Many different remedies have been recommended and used, but more recently the profession have found in Medeol Suppositories an ideal remedy for controlling this condition. Although only mildly astringent, the effect is prompt and the use of one or two Suppositories usually suffices to stop the bleeding. This refers, of course, to the slow oozing ordinarily encountered. If the hemorrhage is quite severe, packing with gauze is indicated. When the bleeding is controlled a Medeol Suppository should be used two or three times a day. These will help to stop the bleeding permanently, through their beneficial effects on the hemorrhoids and rectal tissues. It goes without saying that persistent bleeding from the rectum should lead to the most careful examinations to determine the actual condition.

Chloretone as a Hypnotic and Sedative.

Administered internally, Chloretone passes unchanged into the circulation and is deposited in considerable quantities in the cerebral tissue, the patient falling into a profound sleep. Its action is like that of natural fatigue. Hypnosis passes off gradually, and no habit is formed. Acting upon the central nervous system, therapeutic doses have little or no effect upon the heart and respiratory centers.

Chloretone possesses a wide range of therapeutic applicability. It is a valuable sedative in alcoholism, cholera and colic. It is useful in epilepsy, chorea, pertussis, tetanus and other spasmodic affections. It allays, in most cases, the vomiting of pregnancy, gastric ulcer and seasickness. As a sedative and hypnotic it is indicated in acute mania, puerperal mania, periodic mania, senile dementia, agitated melancholia, motor excitement of general paresis, insomnia of pain (as in tabes dorsalis, cancer and trigeminal neuralgia), insomnia of mental strain, insomnia of nervous diseases, etc. In insomnia it is often effective when other drugs have failed.

The therapeutic dose for an adult is ten to fifteen grains. Good results, however, have been had with doses as small as seven and one-half grains. Sleep usually follows in half an hour to one hour. The administration of Chloretone is not attended with digestive disturbances.

Alcresta Tablets of Ipecac.

Ipecac has long been favorably known to the medical profession. Its value has been recognized by many practitioners in the treatment of amebic dysentery, as an hepatic stimulant and as an intestinal antiseptic.

Physicians who long ago discarded ipecac medication because of the uncertainty of enteric coatings are welcoming ipecac "back to the fold" since it is now possible to administer massive doses of the drug without coating of any kind.

This heretofore unknown method of giving ipecac is made possible through the absorption of ipecac alkaloids with a purified form of hydrated aluminum silicate; and since, in this form, the alkaloids of the drug are not liberated until in the presence of an alkaline solution, the drug passes the stomach unchanged and the alkaloids are liberated in the intestinal secretions.

The reawakened interest in ipecac is due to its proven specificity in amebic dysentery and to the fact that large doses of the adsorbed alkaloids may be taken by mouth without nausea. Given in this way ipecac has been used extensively in a number of diseases where it was heretofore impracticable. It has been shown that the drug possesses decided value in pyorrhea, amebic infections of the tonsils, typhoid fever, and various intestinal disturbances such as flatulence, diarrhea and constipation. The almost startling results that have been attributed to the administration of large doses of ipecac by means of this new compound make it appear that its field in therapeutics is even wider than first anticipated. It is said to be quite possible to give patients the equivalent of one hundred grains of the drug daily without nausea or vomiting and the tablets may be crushed before swallowing.

In addition to these Alcresta Tablets of Ipecac, as this product is known, Ely Lilly & Company, the manufacturers, have recently added to their extensive line an ipecac laxative tablet called Ipelax—a combination of the usual A. S. & B. with the addition of the equivalent of five grains of ipecac in each tablet, a dose heretofore quite unusual in a tablet without an enteric coating.

Interesting researches are being conducted at the Lilly Scientific Laboratories, and in the light of already published information it would seem that ipecac is entering upon a new era in medicine. Interesting literature will be sent our readers by Eli Lilly & Company on request.

Mouth Hygiene is attracting a good deal of attention these days, and while generally accepted as meaning care of the teeth, it is recognized that something more is required to secure mouth hygiene than mere tooth brushing.

The mouth offers a most favorable place for germs to develop, it is of just the right degree of temperature and moisture and there is generally enough food present to make an unclean mouth a veritable incubator for germs of all sorts.

Dioxogen may fairly lay claim to being the best mouth wash available. A liquid germicide, it penetrates to the remotest recesses, where it loosens and detaches adhering materials, purifying and cleansing everything it touches.

Dioxogen contains no flavoring extract to give a false sense of security nor does it contain anything injurious to the teeth - on the contrary it is as harmless as water.

Dioxogen is superior to acetanilid preserved solutions of peroxide of hydrogen for mouth use; it does not turn rank or bitter, is almost neutral in reaction and does not coagulate albumen. Mouth washes that coagulate albumen form a protective coating for germs.

Physician's sample will be gladly sent on request.

THE OAKLAND CHEMICAL CO.
10 ASTOR PLACE NEW YORK.

Prof. Metchnikoff's Opinion:

In calling attention to the fact that in newly-born infants the digestive tracts were perfectly sterile, Prof. Metchnikoff said: "It is my firm conviction that if we could preserve this freedom from intestinal bacteria, we would prevent most of the diseases that can be traced to the action of these germs."

Physicians the world over have agreed with Prof. Metchnikoff in his opinion. Ninety per cent of the ills of mankind have their origin in the colon. To combat these conditions Metchnikoff advocated Bacillus Bulgaricus to kill the germs, a method that is still in the experimental stage. Dr. Diasto recommended colonectomy, somewhat too heroic to be practicable.

A third method, the Internal Bath, for which the "J. B. L. Cascade" was perfected by Dr. Chas. A. Tyrrell, has already been proven the most rational method yet devised for bringing about the results Prof. Metchnikoff so desired to achieve. Physicians who desire to put Dr. Tyrrell's method to the acid test, can obtain the "J. B. L. Cascade" direct from the Institute at special rates. Literature will be mailed on request.

CHAS. A. TYRRELL, M.D.

134 West 65th Street, - - - - - NEW YORK

In Phthisis.

The first and fundamental question which the earnest physician asks to-day in determining the utility of any remedy he wishes to use is "What will it accomplish?" If it does what he asks it to do and does it better than anything else he has every employed, he will certainly use it in preference to anything else. This explains why to-day such a rapidly increasing number of physicians are prescribing Pulmotone as a favorite remedy in the treatment of phthisis. It is an ethical preparation containing ichthyol, creosote carbonate, hydrocyanic acid dil., extract of malt combined with various aromatics prepared expressly for the use of the medical profession. Samples and literature will be forwarded upon request by the R. J. Strasenburgh Co., manufacturing chemists of Rochester, N. Y.

When writing them, ask also for a sample of Muskola, a palatable combination of sedatives, antispasmodics and tonics which the profession has found useful in the treatment of nerve disorders.

Persistent Coughs and Colds.

Colds that linger invariably owe their persistence to inability of the body to exert sufficient resistance to overcome germ activity. Recovery, in consequence, is always largely a question of raising the general vitality and increasing bodily resisting power. To accomplish this, no remedy at the command of the profession is so promptly effective as Gray's Glycerine Tonic Comp. Under the use of this dependable restorative and reconstructive, the appetite is increased, the digestion improved, the nutritional balance restored, and the vital resistance so raised that the body can control infectious processes, and establish a safe and satisfactory convalescence.

In the treatment of colds, therefore, "Gray's" can be relied upon to raise the defensive forces of the organism and fortify it against germ attack.

Antipoliomyelitis Serum.

E. C. Rosenow, Rochester, Minn., after discussing the accounts of work already done describes his method of immunization of horses in his experimental work and the effects of the immune virus in vitro and in the protection of monkeys. The protocols of his experiments on the latter are given, also the numerous agglutination experiments made with the pleomorphic streptococcus with the serums from immunized horses with the serums from patients recovered from poliomyelitis and with the serums of monkeys paralyzed with the virus. He finds that: "1. The serum of horses immunized with aerobic cultures of the pleomorphic streptococcus from both poliomyelitis in man and experimental poliomyelitis in the monkey, developed specific antibodies, agglutinins and complement-deviating properties, the agglutinins appearing to be present in large amount because the serums cross-agglutinate these strains specifically in very high dilutions. 2. The serum of patients and monkeys which have recovered from attacks of poliomyelitis cross-agglutinates specifically many, but not all, of these strains in the lower dilutions. 3. What is of greatest significance, the serum of the horse immunized with recently isolated strains from experimental poliomyelitis in the monkey appears to have developed neutralizing, protective and curative power against the virus of poliomyelitis."—(*J. A. M. A.*)

Metastatic Eye Infections.

In a preliminary report of an investigation of the subject J. M. Levy, New York, assisted by W. F. C. Steinbugler, Brooklyn, and M. C. Pease, Jr., New York, give the results of a study of fifty-seven cases of various eye conditions treated in the Herman Knapp Memorial Eye Hospital during the past year. These were sent there for dental treatment, and the report assumes that these affections, covering quite a large number of eye conditions affecting the iris, cornea, retina, etc., were metastases from dental foci. The general impression which has generally hitherto obtained is that such metastases occur through the blood stream, but the impression from these patients is contrary to this belief. With one exception all the cases cured or materially benefited had the dental disease on the same side as the affected eye which could hardly be expected were the blood stream the channel of infection. The authors have come to the conclusion that these eye metastases from dental foci travel through lymphatic channels. They have attempted to demonstrate the correctness or fallacy of this belief by experiments on animals, but have failed to produce any eye lesions from intravenous or lymphatic injections. They consider it possible that the rabbits used for the experiments were too susceptible and succumbed too readily to the streptococcal infection. A number of cases reported and over 50 per cent. of the whole number of patients were benefited or cured by dental treatment.—(*J. A. M. A.*)

During Pregnancy

STANOLIND Liquid Paraffin is an admirable laxative for use during pregnancy. It produces no irritation of the bowel, has not the slightest disturbing influence upon the uterus, and no effect upon the fetus.

The regular use of Stanolind Liquid Paraffin in the later months of pregnancy is an effective means of avoiding some of the serious dangers attending the parturient state because of sluggish bowel action.

Stanolind Liquid Paraffin counteracts to a definite extent an unfortunate dietetic effect on the intestine in this manner; the concentrated diet of our modern civilized life contains so little indigestible material that the residue is apt to form a pasty mass which tends to adhere to the intestinal wall. Stanolind Liquid Paraffin modifies this food residue, and thus tends to render the mass less adhesive.

Stanolind Liquid Paraffin is mechanical in action, lubricating in effect. Its *suavity* is one of the reasons why increase of dose is never needful after the proper amount is once ascertained.

A trial quantity with informative booklet will be sent on request.

Standard Oil Company

(*Indiana*)
72 West Adams Street
CHICAGO, U.S.A.

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Wilford Hall Laboratories

Port Chester, New York

The most modern plant in America for the manufacture of Surgical Dressings, Plasters, Medicated Soaps, etc.

Breast Feeding.

From his clinical and consultation experience, J. P. Sedgwick, Minneapolis, has become convinced that the lack of information on the subject of breast feeding among physicians is the real cause of most of the needless infant mortality. Persistent demand on the breast is a most important and continually neglected factor in the establishment, maintenance and reinstitution of natural or breast feeding. Normally the flow of breast milk is supposed to be brought about by the hormones just before the milk comes in. He has had no experience with the establishment of lactation without a preceding pregnancy, but many dependable authorities claim that it occurs. The premature infant is usually incapable of furnishing the physiologic sucking stimulus necessary to support the hormones, and if the importance of continued demand on the breast is underestimated breast feeding fails. In the methods used by himself and in the University of Minnesota clinics, in such cases no attempt is made unless the prematurity is very slight to put the babe at breast at once. Both breasts of the mother are expressed regularly five or six times daily by grasping them 1 or 2 cm. back of the areola, and a milking motion carried out toward the nipples without any massage of the breast proper. The ducts which contain the milk extend but a short distance back of the areola. Any one who has milked a cow knows that the teats are milked and not the udder and yet we find nurses and physicians giving instructions to milk or massage the breast gland itself. If his method is generally followed the mother does not lose her milk.

Sedgwick does not discuss agalactia as he has never seen it and doubts its existence. If the baby does not gain well at the breast the trouble is practically always with the baby, or with the quantity but not with the quality of the milk. If the breast milk supply is low the amount the child gets should be determined accurately by a balance, not by a spring scale, and its food requirements supplied by complemental, not supplemental, feeding. The extra food should be given just after nursing and not to replace it. In the maintenance of lactation the same attention should be given to keeping up the demand as in the establishment of lactation. The breast should be emptied at least five times in twenty-four hours. Zlocisti reported the re-establishment of lactation in several cases after the lapse of weeks or even after ninety days, and Sedgwick has no doubt of the accuracy of his views and cites a case in his own experience where relactation was accomplished successfully. He has omitted reference to other aids to make the demand on the breasts more prominent and has neglected the literature purposely. He does not pretend to offer any new discovery, and says we know enough now to save the breast milk for most of the babies now deprived of it.—(*J. A. M. A.*)

Wetnurse Management.

I. A. Abt, Chicago, after pointing out the necessity in infants' hospitals of an ample supply of breast milk, describes the method of management in this regard followed at the Sarah Morris Children's Hospital. They seldom have difficulty in obtaining wet nurses and it has been found best to select women ranging from 20 to 30 years, though still other qualities are more important. The various maternity hospitals and foundling asylums co-operate with them gladly. A nurse of phlegmatic temperament and good morals is preferable though morals are not transmitted through the milk. At the time of admission to the hospital the baby of the wet nurse should be at least 3 or 4 weeks old, and both it and the mother should undergo a complete physical examination, including the Wassermann test and the test for gonococci. One must assure himself that the mother is presenting her own baby, as fraud is sometimes attempted. One must satisfy himself thoroughly that the breast milk is sufficient in quantity and proper in quality. In view of the lack of more scientific methods the quantity of a nurse's milk is judged by weighing the baby before and after nursing. It also may be roughly estimated by expressing the milk by hand and if it dribbles slowly it can be considered deficient. The quality of the milk is best judged by the child's condition. Chemical analysis is not relied on. After passing the physical examination the nurse is admitted to the hospital where room and board are given to her, and she receives a wage of $8 a week, and is required to do some light work, the washing for herself and infant and the care of her room. The nursing of her own baby is insisted on at regular hours to give no chance for stasis to occur. The milk is procured for the foster babies indirectly. Breast pumps are not used, but the mother is instructed how to express the milk, and this is done every four hours during the day and night, all are milked at the same hour under the supervision of a head nurse and assistants, and the details and precautions are described. The milk is received in medicine glasses with flaring top and stem like a goblet and the supervision is strict, as they have found some nurses inclined to dilute the milk with water or substitute cow's milk. In most instances the breast milk is used immediately after obtaining it, but any excess is put into sterile bottles in the refrigerator until needed. The food of the wet nurse during lactation should be sufficient, but not excessive and it should consist as nearly as possible of foods to which she is normally accustomed, taken at regular hours. Personal hygiene and that of the apartment is looked after and ample time to sleep is allowed and some leisure is given in the afternoons between the nursing periods. Menstruation has been found to have little effect on lactation, and the duration of lactation may continue for a long time if stimulation of the breast is maintained. At one time a wet nurse remained at the hospital for eighteen months giving satisfaction, and one has at present been in service for eight months, and the milk supply is not diminished. She produces as high as 56 ounces in twenty-four hours, besides what she gives to her own baby. The average daily amount from each wet nurse, apart from what is given to her own baby, is about 37 ounces.—(*J. A. M. A.*)

Intubation of the Larynx.

H. J. Cartin, Johnston, Pa., gives an analysis of 350 cases of laryngeal intubation occurring in his private practice in a region largely inhabited by foreigners living under unsanitary conditions and inclined to conceal disease through fear of quarantine, and where naturally epidemics of diphtheria are common. The analysis is rather elaborate, but his conclusions from it are given as follows: "1. No patient needing intubation should be denied the chance to live because of lack of hospital facilities. 2. Overcrowding of homes, unhygienic surroundings, concealment of disease, and exposure to contagion are responsible for the epidemics. 3. Lack of trained assistants need not deter one from operating. 4. The use of a tube larger than that indicated for a given age gives better results. 5. Early intubation with large doses of antitoxin reduces the mortality. 6. Wearing the tube five days resulted in fewer reintubations. 7. It appears that special diet and methods of feeding are unnecessary. 8. Reintubation does not seem to affect phonation permanently."—(*J. A. M. A.*)